ASPIRE NETWORK

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Email: info@aspirenetworkmn.org

Referral For Services: Adult Rehabilitative Mental Health Services (ARMHS)

Thank you for your referral to Aspire Network. We will contact the client within 48 hours of receiving your referral to schedule an appointment. We asked that you kindly inform the client of the nature and reason for the referral.

Information of Person Making Referral: Name: _____

Date: _____ Phone number: _____ Fax: _____

Email: _____ Referral Source (Name of

Agency/Organization): _____

Address: _____

Client's Information: Name: _____

Date of Birth: _____ Gender: _____ Ethnicity: _____

Funding source: Medical Assistance_____ UCARE_____ Blue Plus: _____Blue Cross Commercial____

Health Partners: _____Medic: _____ Hennepin Health: _____Health Partners PMAP: _____

Address: _____

Independent Living? Yes No If no, residing with whom? _____

Phone number(s): _____

Emergency contact name: _____ Phone number: _____

Name of legal guardian: _____ Phone number: _____

Presenting concerns: _____

Previous Diagnosis if known: _____

Service Referred to: Adult Rehabilitative Mental Health Services (ARMHS)

For office use only: The client was contacted, and appointment scheduled Yes___ No___ Client did not respond___
Name of person completing referral: _____