HEALING PATH
WELLNESS SERVICES

# Referral For Services

## Referring Agency/Person Information

| | |
|---|---|
| Date of Referral: | Referring Agency/Person: |
| Phone Number: | Email Address: |

## Client Information

| | | |
|---|---|---|
| Client's Name: | | Responsible party/guardian: |
| Date of Birth: | | SSN: |
| Gender: ☐ Male ☐ Female ☐ Other | | |
| Select services that client is being referred for or at risk for (check all that apply)<br>☐ Therapy/Counseling ☐ Mental Health Needs ☐ Community Resources<br>☐ Court Mandated Services ☐ Social/Interpersonal Challenges ☐ Self-Care<br>☐ Substance Use/Abuse ☐ Crisis Assistance<br>☐ Other Reason: _____ | | |
| Address: | | |
| City: | State: | Zip: |
| Home Phone: | | Cell Phone: |
| Permission to leave a message? ☐ Yes ☐ No | | |
| Insurance: | | Subscriber ID: |
| Is an interpreter needed: ☐ Yes ☐ No If yes, what language? _____ | | |
| Is this client currently or previously enrolled in ARMHS/ Therapy? ☐ Yes ☐ No if Yes, when: | | |

Release of Information: Completed (Y / N) (send with form)

Please fax this form to (612)345-4794 or email it to us at referrals@healingpathwellnessmn.com and a staff member will follow-up with the client.