

# Compass North Psychological Services

Phone: 218-999-0051 Fax: 218-999-7020

Please return completed form to Compass north by fax, email [admin@compassnorthpsychological.com](mailto:admin@compassnorthpsychological.com), or drop completed form off at the Compass North office 1200 S Pokegama Ave Ste 160 Grand Rapids, MN 55744

## Adult Rehabilitative Mental Health Referral

Client must be 18+, have MA, IMCare, Health Partners, U-Care or MA eligible and have a diagnosis of mental illness with at least 3 areas of functional impairments. BCBS, Preferred One, and Medica require pre-authorization prior to services being rendered.

**An updated and completed Diagnostic Assessment (DA) is needed if the current DA is more than 1 year old. ARMHS services cannot begin until the DA is complete. Please contact us if you need assistance in getting a Diagnostic Assessment for the referred client.**

Please send completed form with DA to Lindsey Wald via fax or email: [lindsey@compassnorthpsychological.com](mailto:lindsey@compassnorthpsychological.com)

Referring Agency/ Individual: \_\_\_\_\_

Referring Agency Phone Number: \_\_\_\_\_

Diagnostic Assessment Date: \_\_\_\_\_

Diagnosing Clinician: \_\_\_\_\_

### **Client Information:**

Name: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

DOB: \_\_\_\_\_

Race: \_\_\_\_\_

Address: \_\_\_\_\_

Legal Guardian: Y N

City/ State: \_\_\_\_\_

If yes, Name: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Guardian phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact phone number: \_\_\_\_\_

Gender: \_\_\_\_\_

\_\_\_\_\_

### **Client Insurance:**

Type of Insurance: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

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**Medical/ Mental Health Contacts (Please include name, phone number, and location):**

<u>Care Providers</u>	<u>Name</u>	<u>Phone Number</u>	<u>Location</u>
Primary Care Physician			
Psychiatrist/ Medication Manager			
Psychologist/ Therapist			
Case Manager			

**Mental Health Diagnosis:** \_\_\_\_\_

**Summary of symptoms/complaints/needs:** \_\_\_\_\_

**Please check the primary areas in which assistance is needed.**

**Basic Living Skills**

- Budgeting
- Meal Planning/ Grocery Shopping
- Obtaining and Maintaining Housing
- Household Management
- Self-care
- Vocational/Educational
- Transportation
- Obtain/Maintain Financial Assistance
- Medical/ Dental Health
- Children's Needs

**Social Skills/ Crisis Assistance and Community Intervention**

- Social Functioning/ Leisure Time
- Interpersonal Relationship Skills
- Mental Health Symptom Management
- Mental Health Service Needs
- Medication Education
- Chemical Health

**What are your goals for the client in ARMHS:**

**What are the client's goals and motivations for ARMHS:**