REFERRAL FORM
CANVAS HEALTH ADULT INTENSIVE SERVICES

Provider & Dept. referring:_____ Date of request: _____

Practice Name & Street Address: _____

Phone #: _____ **In person** ☐ **ZOOM** ☐ **Both** ☐ **Previous client of Canvas Health?** Yes ☐ No ☐

CLIENT DATA

Please attach any current documentation of DA, FA, D/C Summary, and Medication List as per your release

Name:_____ Birthdate: _____

Address:_____ Phone # - Day: _____

Email:_____ Okay to leave detailed message? Yes ☐ No ☐

Insurance (Primary):_____ Policy #: _____

Policy Holder: (Name, relationship & DOB) _____

*Insurance (Secondary) If any:*_____ *Policy #:* _____

Primary care physician & Clinic: _____

Psychiatrist & Clinic: _____

Individual therapist & Clinic: _____

Current medications: _____

Diagnosis/Symptoms: _____

Describe Client Stressors: _____

Describe Client Goals/Motivation for Treatment: _____

Currently suicidal/homicidal? _____Plan? _____# Past attempts: _____

Previous Diagnostic Assessments within the past year- When: _____Where: _____

Last mental health hospitalization – When: _____Where: _____

Last CD treatment *(if any)* – (Type/When/Where): _____Completed: _____

Please select the option you feel would best suit client's needs:

Adult Day Treatment – *Select one track*

☐ **Connections** (MI) ☐ **DBT Day Treatment** ☐ **DBT Aftercare** ☐ **Symptom Management**

☐ **PACE (lower functioning)**

Unsure – *Select one option*

☐ **Assess for Day Treatment** ☐ **Assess for IOP Group** ☐ **Assess for best program fit**

Mail or Fax to: CANVAS HEALTH ADULT INTENSIVE SERVICES
7066 Stillwater Blvd. N. Oakdale, MN 55128-3937
Fax #: (651) 251-5110 Questions? (651) 251-5020