**Canvas Health ARMHS Program Referral Form**

**Please email this form to** **mmann@canvashealth.org** **or** **tburklund@canvashealth.org** **or fax to 651-251-5111**

**Please note the following information:**

* **\* Denotes required fields for a referral to be made.**
* **If the client is unhoused, please indicate their residential address as such.**
* **If the Client you are referring does not have MA, a PMAP, or an SNBC, then they will be able to self-pay and apply for a sliding scale fee.**
* **New clients to Canvas Health will be required to undergo a comprehensive diagnostic assessment as Canvas Health is a CCBHC.**
* **Canvas Health is certified to provide ARMHS services in Washington, Hennepin, Anoka, Isanti, Chisago, Ramsey, and Dakota counties. For more information on program availability please call 651-251-5038 or email mmann@canvashealth.org.**

**Referral Source Information:**

|  |  |
| --- | --- |
| \*Name:       | \*Phone Number:       |
| \*Agency:       | \*Relationship to Client:       |

**Client Information:**

|  |  |
| --- | --- |
| \*Legal Name:       | \*Legal Gender:       |
| \*Preferred Name:       | \*Gender Identity & Pronouns:       |
| \*Date of Birth:       | \*Primary Phone Number:       |
| Email:       | Secondary Phone Number:       |
| \*Residential Address:       |

**Insurance Information:**

|  |  |
| --- | --- |
| Insurance 1 Type:  | Insurance 1 Company:       |
| Insurance 1 ID/PMI:       | Insurance 1 Policy Holder:       |
| Insurance 2 Type:  | Insurance 2 Company:       |
| Insurance 2 ID/PMI:       | Insurance 2 Policy Holder:       |
| Insurance 3 Type:  | Insurance 3 Company:       |
| Insurance 3 ID/PMI:       | Insurance 3 Policy Holder:       |

**Additional Information:**

* \*Why are you referring the client for ARMHS?

* \*What goal(s) is/are the client hoping to work on with ARMHS?

* \*Does the client have a preferred language other than English? If yes, please list below and do they need an interpreter.

Yes: [ ]  No: [ ]

* \*Are there any safety concerns Canvas Health should be aware of for this client and ARMHS Practitioners? If yes, please elaborate.

Yes: [ ]  No: [ ]

* \*Please describe the client’s mental health and substance use treatment history?

* \*Does the client have a legal guardian? If so, what is their name and contact information (email and phone number). Yes: [ ]  No: [ ]

* \*Does the Client have a Case Manager/Social Worker/Care Coordinator? If yes, please include their contact information. Yes: [ ]  No: [ ]

* Does the client have any mental health triggers Canvas Health should be aware of? If yes, please elaborate.

Yes: [ ]  No: [ ]