Western Mental Health Center
1212 East College Drive
Marshall, MN 56258
Phone: 507-532-3236 / Fax: 507-532-0240
1-800-658-2429

Referral for Mental Health Services

Client Information

Client Name: _____ DOB: _____ SSN:_____ ____Male ____Female
Address: _____
City: _____ State: _____ Zip: _____
Phone Numbers: (home) _____ (cell/work) _____
Legal Guardian: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Numbers: (home) _____ (cell/work) _____

Primary Insurance: _____ ID#: _____
Secondary Insurance: _____ ID#: _____

Referral Source Information

Person making the referral: _____ Agency: _____
County of referral: _____ County Case Manager: _____
Phone: _____ Fax: _____ E-mail: _____

Service Needs

Please check the type of Mental Health service applying for:

___Individual Therapy
___Medication Management
___Family Therapy
___ART
___BHH
___Anger Management Group
___Adult Mental Health Rehabilitation Service (ARMHS) **see questions below**

___Community Support Program (CSP) Criteria:
DX SPMI Yes ____ No _____
___DBT Skills/Group Therapy (separate referral form)
___TCM
___Other: (please list) _____

Has client been seen for other mental health services? __yes __no
(if yes…name of professional and agency)_____

Is there a current Diagnostic Assessment (within past year)? __yes __no
if yes…who completed the DA?)_____

Is CTSS/FCSP recommended in the DA? __yes __no __not applicable

Are other providers involved? __yes __no
(if yes…who? what is the services being provided?)_____

Reason for Referral

Briefly state reason for mental health referral: _____
_____
_____
Indicate any other special circumstances (language barriers, foster care, ect): _____
_____

PLEASE FILL OUT REVERSE SIDE FOR TCM AND BHH – SPECIFIC QUESTIONS

BHH – ADDITIONAL INFORMATION FOR REFERRAL

Primary Diagnosis:____ _____

Secondary Diagnosis:__ _____

Behavioral Health Home Release Reviewed and Signed: Yes ☐ ☐

	Transportation Issues		High Emergenc y Room Use
	Medication Set-Up/Management		Combined Condition:
	Housing Issues		High Screening Score
	Social Services		Multiple Providers
	Community Based Resources		Health and Wellness
	Insurance Assistance		Transitional Care/Planning

Services Requested: BHH services, such as transportation, setting up medication, medication management, and establishing Social Services for receiving in-home assistance with independent living skills.

TCM – ADDITIONAL INFORMATION FOR REFERRAL

Primary Diagnosis:____ _____

Secondary Diagnosis:__ _____

	Transportation Issues		High Emergency Room Use
	Medication Set-Up/Management		Combined Condition:
	Housing Issues		High Screening Score
	Social Services		Multiple Providers
	Community Based Resources		Health and Wellness
	Insurance Assistance		Transitional Care/Planning
	Support Group Services		Help with(in)/formal supports
	Nutritional Issues		
	Spiritual Care		
	Primary Care Referral		
	Diabetes Life Coaching/Diabetic Education		

Specific Concerns/Notes:_____

_____

_____

Questions? Contact WMHC Care Coordination Department

Ph:507-532-3236 or 1-800-658-2429

Send completed referral form to WMHC: include any relevant materials, releases of information, or other supporting documentation if necessary.