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

SUD TREATMENT REFERRAL FORM

Client Information

Client Name: _____ DOB: _____ SS# _____ □ 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: _____

Client Treatment Information

Drug of choice: _____ Last used: _____
How often: (ex. 1x/wk., 3-5x/wk. 1x/mo. etc.) _____
How much: (ex 2 12oz. beers etc.) _____
Withdrawal Symptoms: □Yes □No
Longest period of abstinence: _____
Number of arrest in last 30 days: _____ Number of arrest in last 12 months: _____

A current Diagnostic Assessment within past year with a Chemical Dependent Diagnosis Code is required to process referral?

Date of Diagnostic Assessment: _____ Chemical Dependent Diagnosis Code: _____

Please check the type of Mental Health service applying for:

□ SUD Assessment □ Suboxone □ Other: (please list) _____

Has client been seen for other mental health services? □ yes □ no
(if yes…name of professional and agency)_____

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): _____
_____

Once this form is complete please fax to 507-532-0240 Attention: WMHC Care Coordinator

Send completed referral form to WMHC with ROI, Most Recent SUD Comprehensive

Assessment, Most Recent Progress Note, Most Recent MH Assessment