A picture containing company name

Description automatically generated

**Mental Health Services Request**

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| --- | --- | --- | --- | --- | --- | --- |
| **NAME:** | | | | | page1image2924016  **REFERRAL DATE:** | |
| **DOB:** | **SSN #: (optional)** | | page1image3771312page1image3772144  **GENDER:**  page1image3772768page1image3773184 | | | page1image3773600  **ETHNICITY:**  page1image3774224page1image3774640 |
| **ADDRESS:** | | | | | | **COUNTY:**  page1image3775472page1image3775888 |
| **PHONE:** | | page1image3777968  **EMAIL:**  page1image3778592 | | | **PRIMARY LANGUAGE: INTERPRETER: YES NO**  page1image3779424 | |
| **INSURANCE PROVIDER: Subscriber ID #: Group #:** | | | | | **MA #: PMAP: Yes No (please circle)**  page1image3781088 | |
| **REFERRING SOURCE NAME/AGENCY:**  **REFERRING SOURCE PHONE/ EMAIL/ADDRESS:** | | | | | | |
| **Biological parent or guardian’s Name/ Address/Phone # (if the client is a minor):** | | | | page1image3784416page1image3784832  **Are you comfortable being seen by an unlicensed intern?** Yes No  page1image3785456page1image3785872 | | |
| **AREAS OF NEED/TREATMENT GOALS:** | | | | | | |
| page1image1696416**If available, please include the following records:** ☐ **Diagnostic Assessment (**most recent**)** ☐ **Crisis Plan** ☐ **Rule 25** ☐ **Discharge Summary** ☐ **Functional Assessment** ☐ **IEP** ☐ **Any other supporting documents** | | | | | | |

**Please either fax or send referrals via secure email:**

22 Wilson Ave NE Suite # 109. St. Cloud, MN 56304. **Phone: (**320) 774-1597. **Fax:** (320) 774- 0414 **Email:** [info@bridgehealingcenter.com](mailto:info@bridgehealingcenter.com)