RAMSEY COUNTY
Social Services

Ramsey County Mental Health Center
1919 University Ave. W. Ste 200
St. Paul MN 55104
Welcome Center Phone: 651-266-7890
Fax: 651-266-7850

REFERRAL FORM

Referral Type: ☐ Mental Health Evaluation ☐ Individual Therapy ☐Psychiatry ☐ Adult SUD treatment (CORe) ☐ Youth SUD treatment (YCORe) ☐CTSS ☐ ARMHS☐ Adult Day Treatment ☐Partial Hospital ☐ Group; Specify: (Anger Management, Trauma Group, Social Skills, Men's Empowerment) ☐ Other:

Client's Full Name:	Client's DOB:	SSN:
Name of Insurance:	Policy Number:	
Client's Physical Address:		
Mailing Address (if different):		
Client's Phone Number:	Client's Email Address:	
Permission to leave a message with the client? ☐ Yes ☐ No		
Guardian Name, if applicable:	Guardian Phone Number:	
Interpreter Needed? ☐ No ☐ Yes Language:		
Referral Source Name/Organization/Department:		
Referral Source Address:		
Referral Source Contact Information:		
Phone: Fax:	Email:	
Does the referring party require a copy of the report when complete? ***Note, if yes, a release of information for RCMHC must be completed and attached*** ☐ Yes ☐ No		
Reason for Referral (please include current symptom presentation, relevant legal status, child protection involvement, and any other concerns you may have): Click or tap here to enter text. *Please note, referrals for PHP must include release of information, discharge summary stating specific symptoms and diagnosis, and a recommendation for partial hospitalization programming.		
Signature of Person Making Referral:	Date:	
Please send your referral along with a signed release of information to RCMHC. Fax 651-266-7850 or email SSD.MHCCaseAides@co.ramsey.mn.us.		
Office Use Only:		
Date Referral Received:		
Release of Information Received: ☐ Yes ☐ No		
Evaluation Date: Scheduled By:		
Date Referring Party Notified of Scheduled Evaluation:		
Scan this form into NextGen when complete		