

PEDIATRIC MENTAL HEALTH PROGRAM

REFERRAL FORM

Mino Bimaadiziwin Wellness Clinic
2115 Cedar Ave S., Minneapolis, MN 55404
PH: (651) 396-3070 | FAX: 612-416-2093 | www.rlpmh.org |

CHILD/CLIENT INFORMATION

First Name: _____ Last Name: _____ Suffix: _____
Date of Birth: ___/___/___ Age: _____ Gender: _____ Gender Pronouns: _____
Tribal Affiliation: _____
Descendent or Enrolled: _____
List Additional Race(s): _____
School: _____ Grade: _____
Attends: Baby's Space Bdote Learning Center South High School

PARENT/GUARDIAN INFORMATION

Parent/Guardian aware of the referral: Yes No
Mother (First/Last Name): _____
Father (First/Last Name): _____
Guardian (First/Last Name): _____
Legal documentation of Guardianship: Yes No
Phone: _____ Ok to text or leave voicemail? Yes No Best time to call _____
Email: _____ Mailing Address: _____
City: _____ State: _____ Zip code: _____
Whom to contact for scheduling (Name and Phone Number): _____

REFERRAL SOURCE

Name: _____ Agency: _____
Phone Number of Referral Source: _____

REASON FOR REFERRAL

LEGAL INVOLVEMENT

Is referral court ordered: Yes No Child Protection Involvement: Yes No
County or tribe of court order: _____
Workers Name and Phone Number: _____

MENTAL HEALTH HISTORY

Recent Mental Health Provider(s): _____
Last Date of Diagnostic Assessment: _____

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