PEDIATRIC MENTAL HEALTH PROGRAM

REFERRAL FORM

Mino Bimaadiziwin Wellness Clinic
2115 Cedar Ave S., Minneapolis, MN 55404
PH: (612) 463-9224 | 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: _______________________________

MEDICAL ASSISTANCE NUMBER/Subscriber ID: ____

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