UNIVERSAL REFERRAL FORM	MAKE A REFERRAL DATE OF REFERRAL

Patient Name: _____ Birthdate: _____

Contact Information:

Address: _____ Phone: _____

_____ Mobile Phone: _____

Insurance/health care type:
- ☐ Medical Assistance
- ☐ Medicare
- ☐ MinnesotaCare
- ☐ Commercial
- ☐ VA
- ☐ None

Carrier and ID Number _____

Services you are seeking:
- ☐ Mental Health Services
  - ☐ Adult ☐ Child/Adol
- ☐ Substance Use Disorder
- ☐ Primary Care
- ☐ Other Specialty Provider

_____

Guardian (if any) _____ Phone _____

Health conditions/diagnoses (if known)

Reason for referral:
(i.e., presumptive diagnosis, general description of services needed)

Please attach current medication list.

Referring Provider _____ Phone _____

Clinic/Facility _____ Email _____

Specialty _____ Fax _____