MENTAL HEALTH SYSTEMS INC.

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REFERRAL FORM

Date: ____________________

Name of Referred Person: ______________________________ **DOB**: ____________________

Address: ____

City: ______________________ **State**: ______________ **Zip Code**: ____________

Phone: ______________________ **Gender**: ______________ **Pronouns:** __________

Does the referred person have a guardian or is this person a minor? ☐ Yes* ☐ No*

*Parent/guardian name & phone number (as applicable): ______________________________

Primary diagnosis (if known): ______________________________

Insurance name: ______________________________ **ID #** (if known): ______________

Referral:

☐ Adult DBT

☐ Adolescent DBT

☐ Other (if selected, please provide additional details below)

*Please note MHS is not accepting individual therapy-only clients at this time.

Your name: ______________________________

Email: ______________________________

Agency name (as applicable): ______________________ **Phone**: ______________________

Agency address: ______________________________

Relationship to referred person (parent, doctor, therapist, case manager, etc…): ______________

Please fax this completed form with relevant documentation to (651)383-4935.

Thank you!