MENTAL HEALTH SYSTEMS INC.

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Fax: (651)383-4935
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www.mhs-dbt.com

REFERRAL FORM

Date: _____

Name of Referred Person: _____ **DOB**: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Phone: _____ **Gender**: ☐ Male ☐ Female ☐ Non-binary ☐ Other: _____

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!