**Canvas Health ARMHS Referral Form**

**Referent Data:**

Person Referring:       Date of Request:       Relationship to client:       Agency:       Phone:       Email:

**Client Data:**

Legal Name:            Preferred Name:             Birthdate:

Address:            Phone Number:

Email:            Preferred Language:

Legal Gender:             Gender Identity:                             Pronouns:

Last 4 SSN:             Secondary Phone:

Insurance:            Policy Number:

**Care Information (provide name, agency/clinic, and phone number for each):**

Primary Care Physician:

Psychiatrist:

Psychotherapist:

County Case Manager:

Other ARMHS Provider(s) (within 3 years):

Mental Health Diagnosis with F code(s):

Client’s Current Stressors (select all that apply):  Social [ ]    Academic [ ]  Emotional [ ]    Behavioral [ ]

Self-Care [ ]   Occupational [ ]    Other [ ]

Preferred Location of Services (can select multiple):

Telehealth [ ]   Home [ ]  Clinic [ ]  Community [ ]

**Reason for ARMHS:**

What are the client’s goals and motivations for ARMHS?

Is the client aware of referral to ARMHS?

Yes [ ]  or No, this is a requirement for ARMHS [ ]

Is the client in agreement with receiving ARMHS service?

Yes [ ]  or No, this is a requirement for ARMHS [ ]

**What are the goals areas you and the client want to focus on? (Please describe any box checked below. There must be at least 3 functional needs identified.)**

Self-care (ex. personal hygiene, ability to schedule/attend appointments, completing paperwork): [ ]      Family Relationships: [ ]

Socialization: [ ]

Vocational: [ ]

Housing and Financial Management: [ ]

Currently suicidal/homicidal (review history, attempts, and current plan): [ ]

Hospitalizations (when and where): [ ]

Transportation (does the client drive? Resources?) [ ]

Client strengths:

Describe any boxes checked above here:

Has an ROI been obtained from client? If not, what is your plan for obtaining one?

**Return this form to Canvas Health ARMHS in one of the following methods:**

Encrypted Email to:

mmann@canvashealth.org

cc tburklund@canvashealth.org

subject line: Canvas Health ARMHS Referral

Fax to:

651-251-5111

Mail to:

Canvas Health attn. ARMHS

7066 Stillwater Blvd N,

Oakdale, MN 55128-3937

**Information/Directions for completing this form- if the following directions are not properly observed this referral will be sent back or rejected without processing:**

1. Complete this form with the potential client.
2. A release of information for this potential client will be required to ensure proper coordination of care and exchange of information. If one is in the process of being obtained, please explain in the proper space above.
3. If you will be sending a current functional assessment (completed in the last twelve months) in lieu of completing the functional area question in the Reason for ARMHS portion of this referral, please note if the functional assessment does not include the needed information needed this referral may be sent back.
4. If the potential client does not have an active Medicaid product for their insurance, MNsure Navigators are available to assist with questions and application help, free of charge.
5. Medicaid insurance products are not a requirement for Canvas Health ARMHS. There are self-pay and sliding fee scale options. To learn more please call 651-251-5038.
6. Canvas Health is certified to provide ARMHS in Anoka, Dakota, Chisago, Hennepin, Isanti, Ramsey, and Washington counties. **For up-to-date information regarding waitlists, if we are accepting referrals in each county, etc. please call 651-251-5038.**