AMHERST H. WILDER FOUNDATION

REFERRAL FORM FOR CHILDREN'S MENTAL HEALTH SERVICES

451 Lexington Parkway North, St. Paul, MN 55104 Fax: 651-280-3155

Is the client in immediate crisis or suicidal? **Call 911** or Children's Crisis Response: 651-266-7878

Referring for: ☐ Southeast Asian Services 651-280-2687 ☐ General Children's Mental Health 651-280-2431
(For clients needing/wanting a bilingual or bicultural provider)

REFERRED BY

Name: _____ Role: _____

Clinic/Telephone: _____

Reason for Referral:_____

_____

CLIENT INFORMATION

Name: _____ DOB: _____ Gender: _____

Address: _____ Phone: _____

PARENT/GUARDIAN INFORMATION

Name(s): _____Phone: _____

Address (if different than child's):_____

Legal Guardian (if not parent):_____Phone:_____

Address:_____

Insurance Provider: _____ Member #: _____

English Ability of:

Parent: ☐Fluent ☐Good ☐Limited ☐None, Primary Language:_____

Child: ☐Fluent ☐Good ☐Limited ☐None, Primary Language:_____

☐ Requesting an Interpreter Requesting Transportation: ☐Y ☐N

CONSENT TO RELEASE INFORMATION

- I consent to have my clinic share the information on this form with Wilder's Mental Health Services and that they will contact the identified caregiver.
- I consent to have the Wilder Foundation provide feedback to my clinic about the status of this referral for mental health.
- I understand I may refuse to sign (and can revoke) this referral and consent, except to the extent that action has already been taken in reliance on this consent.
- I understand that my clinic may not condition my treatment/service or payment of my bills on my decision to sign this referral and consent form.
- I understand that when the information specified on this form is sent to the Wilder Foundation's Mental Health Services, they have agreed not to re-disclose the information to any third party other than this clinic and to protect the privacy of this information consistent with state and federal privacy laws.
- I agree that a photocopy of this form is as valid as the original.
- I understand that, upon my request, I will receive a copy of this signed form.

I have read and agree to the terms above _____Date_____

(Parent/Legal Guardian Signature)

Wilder Administrative use only

Date of Referral: _____ Referral Taken By: _____

Referral made to staff: _____ _____
Name Date

NOTE: Please let the client and parent(s)/guardian(s) know that you have made this referral and that we will be contacting them to schedule an appointment. Most clients begin by having a diagnostic assessment appointment with one of our mental health clinicians in order to assess the client's current mental health and service needs and discuss any concerns with parents/guardians. As always, we appreciate the opportunity to work with you and look forward to collaborating.

Fax completed forms to: 651-280-3155

451 Lexington Parkway North, Saint Paul, MN 55104 www.wilder.org

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Here for good.