COMMUNITY MENTAL HEALTH & WELLNESS SERVICES REFERRAL FORM

AMHERST H. WILDER FOUNDATION
Here for good.
451 Lexington Parkway North | Saint Paul, MN 55104
wilder.org | 651-280-2310
Send Referrals: 651-280-3995 (fax) | referrals@wilder.org (encrypted emails only)

If the client is in immediate crisis or suicidal Call 911 or
Adult Crisis Response 651-266-7900; Children's Crisis Response 651-266-7878

REFERRED BY ◯ Self ◯ Other

Name _____ Role _____

Organization Name _____ Direct Phone _____ Fax _____

Reason for Referral (provide description):

CLIENT INFORMATION

Name _____ DOB _____ Gender _____

Address _____ Phone _____ Alt Phone _____

PARENT/GUARDIAN INFORMATION

Pare◯ Leg◯Guardian Name(s) _____ Address

(if different than child) _____ Phone _____

ENGLISH FLUENCY

Client ◯ Fluent ◯ Limited ◯ None Primary Language _____

Parent/Guardian ◯ Fluent ◯ Limited ◯ None Primary Language _____

☐ **Request an Interpreter**

INSURANCE PROVIDER _____ Member # _____

What type of services are you referring the client for?

◯ Outpatient Psychotherapy Services
◯ Assertive Community Treatment (for referral, DA must be no older than 180 days)
◯ Center for Social Healing
◯ Chemical Dependency/Recovery Services (adults only)
◯ Mental Health Case Management (children or adults)
◯ Other _____

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/services 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.

X Client/Parent/Legal Guardian Signature _____ 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 our collaboration. 2/2021