Amherst H. Wilder Foundation
REFERRAL FORM FOR COMMUNITY MENTAL HEALTH SERVICES
451 Lexington Parkway North, Saint Paul, MN 55104
www.wilder.org
651-280-2310 Fax: 651-280-3155

Is the client 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 _____

Clinic _____ Direct Phone _____ Fax _____

Reason for Referral:
(provide description)

CLIENT INFORMATION

Name _____ DOB _____ Gender: _____

Address _____ Phone _____

PARENT/GUARDIAN INFORMATION Alt. Phone _____

Name(s) _____ Phone _____

Legal Guardian *(if not parent)* _____ Phone _____

Address *(if different then child's)* _____

ENGLISH FLUENCY

Client: ☐ Fluent ☐ Limited ☐ None PRIMARY LANGUAGE _____

Parent/ Guardian: ☐ Fluent ☐ Limited ☐ None PRIMARY LANGUAGE _____

☐ Requesting 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 then 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 collaborating.