**Metro Care Treatment Program**

**Internal Referral Form**

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| **Referral Source Information:**  **Person Making Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Referral Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Office Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Personal Information**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| First Name: | | | M.I.: | Last Name: | | |
| Date of Birth: | Gender:  Male  Female  Prefer not to answer  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Race: | | SSN: |
| Address: | | | | City: | | Zip code: |
| Phone Number: | | Cell Number: | | | E-mail address: | |

**Reason for Referral request:**

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Client referred for: (check one or more boxes below)

Substance Abuse – Assessment (to determine level of care needed)

Outpatient Treatment

Do you have a Current SUD or Rule 25 Assessment ( within the last 30 days )  Yes  No

Previous Assessments  Yes  No

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| Where/When: |

Previous Treatments?  Yes  No

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| Where/When: |

**Funding: Insurance**

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| Primary insurance: ***(please check box)***  **UCARE**   MEDICA  Health Partners  Blue Cross Blue Shield  Hennepin Healthcare  Metropolitan Health Plan  Straight MA  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | PMI Number:  Medical Assistance Number: |
| Primary Ins. # Group # | Other insurance information: |

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| CCDTF(Rule 25 Funding)  Yes  No  County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Worker’s Name who approved \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Rule 25/Comprehensive Assessment**

Most Recent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Program/Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Assessments dates/ company? Assessor /

|  |
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***Referrals can be emailed***

***E-mail: mailto:irts.info@metrocareservicesmn.com Subject: Substance Abuse Referral***

**For Metro Care Human Services Use Only**

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| Referral Status:  Appointment Scheduled: Date:\_\_\_\_\_\_\_\_\_\_\_ Clinician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client unable/declined (circle) to schedule:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Not scheduled Due to (circle) to schedule \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Not scheduled due to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Added to calendar  Staff Member completing this form:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |