**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**

|  |  |  |
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| 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |