Metro Care Treatment Program

Internal Referral Form

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:

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

Where/When:

Previous Treatments? ☐ Yes ☐ No

Where/When:

Funding: Insurance

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:

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 /

Referrals can be emailed
E-mail: mailto:irts.info@metrocareservicesmn.com -Subject: Substance Abuse Referral

For Metro Care Human Services Use Only

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:_____