Outpatient SUD Referral Form

Referral Agency:		**Referral Date:**	
Referral Name:		**Referral Phone:**	

Client Information			
Client Name:		**Address:**	
DOB:		**City / State:**	
Phone:		**Zip:**	

Insurance Coverage	
MA / PMI:	
PMAP:	
PMAP ID#:	

Diagnostic Assessment Completed?	☐ Yes ☐ No
Date Diagnostic Assessment Completed:	
Location Diagnostic Assessment Completed:	
Qualifying Diagnosis on DA:	

Location Preferred	☐ Duluth ☐ Cloquet	**Services Seeking**	☐ ARMHS ☐ Targeted Case Management

Client Goal Areas			
☐ Mental Health Symptoms / Services ☐ Independent Living Skills	☐ Chemical Use ☐ Medical ☐ Education	☐ Housing ☐ Dental ☐ Social Skills	☐ Financial ☐ Employment ☐ Transportation

Please send to: info@WebMedMN.com or via fax (218) 206-6276