NORTHWEST
SOLUTION SERVICES

Make a Referral

Mental Health /Behavioral Health Services

Name of referred person ______________________ Birthdate ____________ Gender M ◯ F ◯

Address ______________________________________ City ____________

State ____________ Zip Code ____________ Phone ____________

Services you are seeking:

- o *Adult Mental Health Services*
- o *Diagnostic Assessment*
- o Housing Stabilization Services

Primary diagnosis (if known) ______________________________

Reason for referral

Current living situation:

- ◯ Private Home/Apt.
- ◯ Foster Care
- ◯ Board & Lodge
- ◯ IRT
- ◯ RTC
- ◯ Nursing Home
- ◯ Homeless/Shelter
- ◯ Jail/Prison
- ◯ Other

Guardian (if any) ______________________ Phone ____________

Case manager/agency (if any) ______________________ Phone ____________

Name & agencies of other Mental Health/Behavioral Health providers:

Insurance/health care type:

- ◯ Medical Assistance
- ◯ MinnesotaCare
- ◯ VA
- ◯ Medicare
- ◯ Private/Commercial
- ◯ None

Insurance carrier (ie. Medica) ______________________ Insurance ID number ____________

Requested start date ____________

Name person making request ______________________ Phone ____________

Relationship to referred person ______________________

How best to contact:
(list whom to contact, days, hours, times & phone numbers where it is best to reach them)

Signature ______________________ Date ____________

Call with questions: **Moorhead MN Tel:** 218.**216.8745** | Fax: **218.331.1275**

Mail: **1819 30th ave s Suite 203**, **Moorhead**, MN **56560**