REFERRAL FORM FOR WAITING LIST AND ADMISSION

RECOVERY PLUS ADOLESCENT SERVICES
1572 COUNTY ROAD 134
ST. CLOUD, MN 56303
ADMISSIONS PH: 320-255-7738 EXT. 79888 FAX: 320-229-5009

Client's Name (First, Middle, Last): ______________________ **SS#:** ___ - __ - ____

Address: ______________________

Date of Birth: __ / __ / __ **Place of Birth:** __________ **Race:** __________ **Ethnicity:** __________

County: __________ **Religion:** __________ **Church:** __________ **Preferred Language:** __________

Parent/Guardian: ______________ **Home Number:** __________ **Cell Number:** __________

Address (if different from above): ______________________

Parent/Guardian: ______________ **Home Number:** __________ **Cell Number:** __________

Address (if different from above): ______________________

Who has primary custody/guardianship? ______________ **Is there court documentation to support custody?** ______

Current Care Team:

Current School and Contact Person: ______________ Phone Number: __________

Grade: ______ **IEP/504 Plan?** ______

Social Worker and County: ______________ Phone Number: __________

Probation Officer and County: ______________ Phone Number: __________

Mental Health Worker and County: ______________ Phone Number: __________

Rule 25 Worker and County: ______________ Phone Number: __________

Guardian Ad Litem: ______________ Phone Number: __________

Primary Therapist/Counselor and Clinic Name: ______________ Phone Number: __________

Primary Psychiatrist and Clinic Name: ______________________

Primary Care Doctor/Physician and Clinic Name: ______________________

Others involved: ______________________

Food Allergies or Special Dietary Needs: ______________________

Insurance/Funding:

Name of Insurance Company: ______________

Group #: __________ **Member ID:** __________

Primary Policy Holder's Name, Employer, and Date of Birth: ______________________

Secondary Funding Source and ID (if applicable): ______________________

Name of Guarantor, Employer and Date of Birth (if different from above): ______________________

Please submit this form along with a chemical health assessment that was completed no more than 30 days ago, clients are not eligible for any opening until we have a current copy of their assessment. Please also submit most recent Diagnostic Assessment and/or Psychiatric Evaluation if completed.