

Office Use Only

# Zumbro Valley Mental Health Center Referral Application

Send all referrals to: Central Intake, 343 Woodlake Drive SE, Rochester, MN 55904  
Phone: 507-289-2089 Fax: 507-289-2327

### Check all applicable programs

**Community Support Programs**

- Day Treatment
- Skills classes (ARMHS)
- ICRS
- Outreach
- Fillmore County Programs

**Housing Options**

- Homeless Services Team
- Housing Options
- Residential Treatment
- Thomas House

**Psychiatry/Psychotherapy**

- Outpatient Chemical Health
- Outpatient Mental Health
- Adult Psychiatry
- Child Psychiatry
- Med Options II
- Adult Mental Health
- Child Mental Health

**Recovery Programs**

- Recovery Basics
- Recovery Partners
- PREP
- Right to Recovery
- Choices/DWI (circle)
- Chronic CD/homeless
- Other \_\_\_\_\_

*Note: Case management referrals go through OCDSS at 507-285-7009.*

\_\_\_\_\_  
Referral Source (print)

\_\_\_\_\_  
Referral Address/Agency

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Number Street City State Zip Code

Phone: \_\_\_\_\_ Marital Status: S M Sep D W Children \_\_ County \_\_\_\_\_

Education: \_\_\_\_\_ Employment Status: \_\_\_\_\_

Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_  
(issues, symptoms, stressors) \_\_\_\_\_  
\_\_\_\_\_

### Current Diagnosis Information (attached current Dx assessments)

DSM IV Mental Health/Chem Abuse/ Dependency	AXIS 1	1. _____	Code: _____
		2. _____	Code: _____
	AXIS 2	1. _____	
		2. _____	

<b>Current Medications:</b>		
_____		
_____		
Allergies: _____		
_____		
Psychiatrist:	Agency:	Phone:
Therapist:	Agency:	Phone:
Physician:	Agency:	Phone:
Case Manager:	Agency:	Phone:
Financial Worker:	Agency:	Phone:
Other (probation, A/T, clergy):		Phone:
Past treatment (previous 2 years): _____		
_____		

<b>Psychiatric (inpatient, outpatient, residential)</b>		
_____		
_____		
_____		
Chemical Dependency (inpatient, outpatient, residential)		
_____		
_____		
Alcohol/drug abuse:	Past suicide attempts	_____
Victim physical abuse:	History of fire setting:	_____
History of self-abuse	Homeless or at risk:	_____
History of assaultive behavior:	Probation (until _____):	_____
History of sexual abuse:	P.D. (until _____):	_____
Legal issues:	Commitment history:	_____
History of homicidal thoughts or verbal threats:	Stay of commitment:	_____
_____		

<b>Medical concerns/needs:</b>					
_____					
Date of last physical exam:		Location:			
_____		_____			
Concerns about current living arrangement: _____					
Source of income (circle):	SSI	SSDI	GA	VA	Wages
Health insurance (circle):	Medicare	Medicaid	Other:	_____	
Total monthly income:	_____		Social Security Number:	_____	
County of Financial Responsibility:	_____		MA Number:	_____	
Additional Information:					
_____					
_____					

Please attach Diagnostic Assessment if available and return to Zumbro Valley program central intake.