

Adult Mental Health Intake Referral Form

Referral Contact Information		
Referral Date:	Referral Type:	
Referral Source (Name & Position):		
Phone:	Fax:	Email:
Address:		
Client/Legal Guardian provides consent for this referral: Y N		

Client Information		
Name:	DOB:	Gender:
Legal Name:	Pronouns:	Race:
Phone:	Email:	
Address:		
Permanent Address:		
Preferred Language	Interpreter Needed:	Y N
Current Employment Status: Employed Un-Employed	Location:	

Power of Attorney/Legal Guardian	
If you are POA and/or Legal Guardian, please provide supporting documentation	ROI Submitted to Mental Health Intake fax with referral
Name:	Relationship:
Phone:	Email:
Address:	
Preferred Language	Interpreter Needed: Y N
Additional Family Information:	

Current Symptoms (Mental Health and/or Substance Use):

Service(s) Requesting:

How to Establish Initial Contact with Behavioral Health Intake:	
Client/POA/Legal Guardian will initiate contact with BH Intake (please give them the contact #: 763-324-1420)	
Client/POA/Legal Guardian has requested that BH Intake contact them (please provide name/phone #)	
Name:	Phone:
Fax or email all required documents listed above to 763-324-3640 (fax) or RS-HS-AMHintake@anokacountymn.gov	