Five Rivers Mental Health Clinic LLC
1650 Madison Ave., Ste. 102, Mankato MN 56001 Phone: 507-345-7012 Fax: 507-388-6937

CTSS Referral Form

Referral Source Information

Name & Agency:	**Phone:**
Email or Fax:	**Referral Date:**
How did you hear about Five Rivers?	

Client Information

Name:	**DOB & Age:**	**Address:**
Race/Ethnicity:	**Gender:**	**City:**
Phone:	**Message OK? Y / N**	**Insurance:**

Parent or Guardian Information

Name:	**Phone:**
Relationship:	**Address:**

Mental Health Information

Current mental health services:
Current medications:
Current diagnosis:

___ **A signed/dated consent for release of information is attached to this referral (required).**

Date of most recent diagnostic assessment: _____
(please note: if most recent DA was completed more than 11 months ago, an updated DA will be required before client can begin services)

Reason for Referral

Please describe current treatment and potential goals to be addressed through skills training

Other Relevant Information (including other supports such as social worker, GAL, individual therapist)

Please fax referral form to 507-388-6937 Attn: Nicole Olsen
Please contact Nicole with any questions – 507-345-7012 x. 4 or nicole@fiveriversmhc.com

Office Use Only

Date Received	Referral Source Contacted Y / N
Assigned to	Appointment Date