Referral Form

Referral to Community-based Mental Health Services

Please complete this form to the best of your knowledge and return to the Cambia Hills Community-based Program:

Fax: 218-728-7467/ **E-mail**: community@thehillsyfs.org / **Phone**: 218.623.6476

You will be contacted within three business days to verify receipt of your referral. Thank you for choosing Cambia Hills!

Child's Information

Full Name	Nickname		Gender identity: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say	
Date of Birth	Place of Birth		Social Security No.	
Last Known or Permanent Address	City		State	Zip
Home Phone	Current Placement or location		Age	
Race/Ethnicity	Primary Language		Spiritual or religious affiliation	
Tribal Affiliation, if any	Is child adopted? ☐ Yes ☐ No	Age at first adoption?	# finalized adoptions?	Is child a State Ward? ☐ Yes ☐ No
Medical Insurance Provider and Policy No. Primary:		Secondary:		

Child's Profile

What are the presenting problems in your perspective?
What is the history of or contributing factors to the child's problems?
What are some of the child's assets, strengths, interests or abilities?
Any other important information?

History of Services Delivered

Outpatient Services (therapy, day treatment, etc.)

Name of Agency	Dates of Service	Result

Residential/Inpatient Services

Name of Agency	Dates of Service	Result

Legal History? ☐ Yes ☐ No

Current and Prior Offenses	Class/Degree of Offense	Offense Date	Disposition

Contact Information

Parent/guardian

(1) Parent/Guardian name	Parent's Date of Birth	Does child live with this parent? ☐ Yes ☐ No	
Street Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
(2) Parent/Guardian name	Parent's Date of Birth	Does child lives with this parent? ☐ Yes ☐ No	
Street Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	

Who has custody of the child?

Any restrictions on either parent's involvement?

☐ Yes ☐ No If yes, what?

Will the parent(s/guardian(s be supportive of mental health services?

☐ Yes ☐ No If no, why?

Other Professionals Currently Working with this Child

Agency	Worker's Name	Phone	Involved in treatment? ☐ Yes ☐ No
Agency	Worker's Name	Phone	Involved in treatment? ☐ Yes ☐ No

Please submit to our admissions at Community@thehillsyfs.org and we will get to back to you as soon as we can.