579 Wells Street
Saint Paul, MN 55130

Phone: (651) 793-3803
Fax: (651) 793-3809

Mental Health Services Referral Form

Thank you for your referral. Our agency will contact you to confirm that the referral has been received. Please discuss the nature and intent of this referral with your client. We will contact the client to schedule an appointment.

Referral Date: ________________ Referral Contact Phone: __________________ Referral Fax: __________________

Referral Source (Name and Agency) ____

Referral Address: ____

Client Name: ___________________________________ Date of Birth: ______________ Gender: _______________

Parent/Guardian Name (if Client is a child or adolescent): ____

Tribal Affiliation/Descendency: _______________

Enrollment # (if known/applicable): _________________ SS #: ____________________

Address: ____

Phone: _________________________ Email: ____________________________

Other Important Contact Information: ____

Other Important Phone Numbers: ____

Does Client have Insurance? Yes: No: None (provider service referral needed):

Medicaid # (if known): ____________________

Presenting Concerns/Comments (attach additional sheets as necessary):

____

____

Diagnosis (if known): ____

Please complete this form and return to Caitlin Langer, Behavioral Health Admin Specialist at Caitlin_Joyce@aifc.net.

Questions regarding AIFC Mental Health Services can be directed to Jessica Gourneau,Clinical Director at Jessica_Gourneau@aifc.net or by phone at (651) 793-3803.

Where American Indian Families Thrive!