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 Tanya Hausladen, Behavioral Health Care Coordinator/Billing Specialist at Tanya.Hausladen@aifcmn.org.
Questions regarding AIFC Mental Health Services can be directed to Steve Luzar, Clinical Director at Steve.Luzar@aifcmn.org or by phone at (651) 793-3803.

Where American Indian Families Thrive!