Serenity Mental Health Services

225 3rd Ave. NW Hutchinson, MN 55350
Phone/Fax: (320) 455-9888/(320) 587-5390
http://SerenityMentalHealthServices.com
admin@serenitymentalhealthservices.com

Program individual is being referred for: ☐ ARMHS ☐ CTSS ☐ THERAPY

Client Name: _____

DOB: _____ Age: _____ Sex: _____

Address: _____

Contact Phone/Name: _____

Race: _____ Ethnicity: _____

Tribe Member: ☐ Yes / ☐ No If so, Tribe: _____

Children:

Parents Name and Address (if different from above): _____

Legal Guardian: _____

Statement of Problem (please attach any documentation/background information which may be helpful:

_____

_____

_____

_____

_____

Diagnosis (if known): _____

Foster Care Provider Name/Address (if Applicable): _____

Social Worker Name/Address: _____

Individual Therapist Name/Address: _____

Guardian ad Litem Name/Address: _____

Other Professionals: _____

Primary Insurance Company: _____ ◉MA ○PMAP ○Commercial
Insurance ID#: _____ Group #: _____
Subscriber: _____ Subscriber DOB: _____

_____ _____

Date of Inquiry Person Completing Form/Relation to client

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(SMHS Staff completes) Date Insurance Verified: _____

Services covered under insurance: _☐_ CTSS _☐_ ARMHS _☐_Therapy

Date of Last Diagnostic Assessment/Name of Provider: _____
(if no Diagnostic Assessment completed 180 days prior to onset of services, one must be completed prior to initial visit with family).

DA/Intake Scheduled for: _____

With: _____

Practitioner Assigned:_____

Initial Meeting Scheduled:_____

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