Therapy Referral Form

Please complete the requested PDF form and email it to referrals@rti-mn.com - For questions please call our Main Office 651-457-1461

PORTAGE MENTAL HEALTH

REFERRAL INFO

DATE OF REFERRAL: _____ REFERRED BY/RELATIONSHIP: _____

AGENCY & ADDRESS: _____

PHONE: _____ FAX: _____ EMAIL: _____

CLIENT INFORMATION

NAME: _____ DOB: fff Preferred Gender Pronouns: _____ PMI: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE: _____ EMAIL: _____ GENDER: _____ RACE/ETHNICITY: _____

GUARDIAN: ☐ NO ☐ YES: _____

FIRST LAST PHONE EMAIL

1) Are they currently receiving services through RTI: ☐ NO ☐ YES: _____
2) Preferred method of therapy: ☐ Telehealth ☐ In person
3) Frequency of therapy requesting: ☐ Bi-weekly ☐ Monthly ☐ Other: _____
4) General reason person is seeking therapy services: _____
5) Client availability to meet for therapy: _____

DAYS TIMES

ADDITIONAL INFORMATION

SPEND DOWN: ☐ NO ☐ YES MEDICARE: ☐ NO ☐ YES MEDICAL ASSISTANCE #: _____

MANAGED CARE ORGANIZATION: _____ INSURANCE ID: _____

MENTAL HEALTH INFORMATION

MENTAL HEALTH DIAGNOSIS(ES): ☐ MAJOR DEPRESSION ☐ BIPOLAR DISORDER ☐ BORDERLINE PERSONALITY DISORDER
☐ SCHIZOPHRENIA ☐ SCHIZOAFFECTIVE DISORDER ☐ OTHER: _____

(Please attach a Release of Information for the following)

PSYCHIATRIST & CLINIC: _____ PHONE: _____

ADDRESS: _____ FAX: _____

THERAPIST & CLINIC: _____ PHONE: _____

ADDRESS: _____ FAX: _____

CLINICAL DOCUMENTS

THE FOLLOWING MUST BE SELECTED TO COMPLETE THE REFERRAL

Please Complete Questions 1 and 2:

1. Does the individual have a current DA within 12 months? ☐ YES ☐ NO
   (Please include the Diagnostic Assessment with the referral form)
2. Please indicate Client's availability to schedule a Diagnostic Assessment with RTI's Clinician:

   Preferred Days: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

   Preferred Times: Contact client directly to schedule