

Adult Rehabilitative Mental Health (ARMHS) SERVICE REQUEST



NAME			COURAGE CENTER CLIENT SERVICES DEPARTMENT PH: 763-520-0312 FAX: <u>763-520-0392</u>
DOB	Male or Female?	MARITAL STATUS	
PHONE		2ND PHONE	
ADDRESS			
CONSERVATOR/GUARDIAN		PHONE	
SCHEDULING CONTACT		PHONE	
EMERGENCY CONTACT		PHONE	
COUNTY			
MN Health Care Program #		HMO if applicable:	
*ETHNIC ORIGIN		*PRIMARY LANGUAGE	
*Because we are partially funded by United Way, we ask for ethnic origin & primary language for reporting statistics.			
PRIMARY PHYSICIAN		PHONE	
PSYCHOTHERAPIST		PHONE	
PSYCHIATRIST		PHONE	
MENTAL HEALTH/BRAIN INJURY DIAGNOSIS:		ONSET	
		ICD-9 CODE	
SECONDARY DIAGNOSIS/DISABILITY		ONSET	
		ICD-9 CODE	
SPECIAL MEDICAL CONCERNS:			
Criminal History? Yes or No?			
CURRENT MEDICATIONS			
CASE MANAGER NAME		PHONE	
REFERRAL SOURCE		PHONE	
AREAS OF NEED			
ATTACH RELEASE OF INFORMATION ATTACH MOST CURRENT MENTAL HEALTH DIAGNOSTIC ASSESSMENT, IF AVAILABLE _____ (✓) if Diagnostic Assessment Needed			