**Mino Bimaadiziwin Wellness Clinic - Red Lake Nation**
2115 Cedar Ave S.
Minneapolis, MN 55404
Phone: 612-767-7892 · Fax: 612-315-3951

# Referral Form

**Date:**

## CLIENT INFORMATION

Client Full Name: _____

Guardian Full Name (if client is minor): _____

DOB: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ OK to text? ☐Yes ☐No

Alternate phone number: _____ OK to text? ☐Yes ☐No

Email: _____ OK to email? ☐Yes ☐No

MA Number: _____

Tribal Affiliation: _____ ☐Enrolled or ☐Descendant

Do you already receive services with Mino-B Wellness Clinic? ☐Yes ☐No

If yes, what services and with whom? _____

_____

## REFERRAL SOURCE

Name of referrer: _____

Agency/Organization: _____

Phone Number: _____ Fax Number: _____

Referred through an outreach event? ☐Yes, (please specify)_____ ☐ No

☐ Self-referral – How did you hear about Mino-B? _____

## SERVICE NEEDED

☐Mental Health Therapy ☐Community Health Worker

☐Targeted Case Management ☐Mino-B Apartments (Supportive Housing/GRH)

☐Psychological Testing ☐Diagnostic Assessment

☐Care Coordination ☐Comprehensive Assessment

☐Cultural or Spiritual Service ☐Other: _____

Previous diagnoses (if known): _____

_____

**Please provide a brief description of the reason for referral:** _____

_____

_____

_____

**ADDITIONAL NOTES:**