** Rayk Wellness Center**

**Rayk Wellness Center ARMHS Program Referral Form**

**Please email this form to** [**Raykwellnesscenter@gmail.com**](mailto:Raykwellnesscenter@gmail.com) **or fax to 763 439 1742**

**Please note the following information:**

* **\* Denotes required fields for a referral to be made.**
* **If the client is unhoused, please indicate their residential address as such.**
* **If the Client you are referring does not have MA, a PMAP, or an SNBC, then they will be able to self-pay and apply for a sliding scale fee.**
* **New clients to Canvas Health will be required to undergo a comprehensive diagnostic assessment as Rayk Wellness center is a CCBHC.**
* **Rayk Wellness center is certified to provide ARMHS services in Carver, Hennepin, Ramsey and Dakota counties.**
* **For more information on program availability please call 763 439 1742 or email** [**Raykwellnesscenter@gmail.com**](mailto:Raykwellnesscenter@gmail.com)**.**

**Referral Source Information:**

|  |  |
| --- | --- |
| \*Name: | \*Phone Number: |
| \*Agency: | \*Relationship to Client: |

**Client Information:**

|  |  |
| --- | --- |
| \*Legal Name: | \*Legal Gender: |
| \*Preferred Name: | \*Gender Identity & Pronouns: |
| \*Date of Birth: | \*Primary Phone Number: |
| Email: | Secondary Phone Number: |
| \*Residential Address: | |

**Insurance Information:**

|  |  |
| --- | --- |
| Insurance 1 Type: | Insurance 1 Company: |
| Insurance 1 ID/PMI: | Insurance 1 Policy Holder: |
| Insurance 2 Type: | Insurance 2 Company: |
| Insurance 2 ID/PMI: | Insurance 2 Policy Holder: |
| Insurance 3 Type: | Insurance 3 Company: |
| Insurance 3 ID/PMI: | Insurance 3 Policy Holder: |

**Additional Information:**

* \*Why are you referring the client for ARMHS?

* \*What goal(s) is/are the client hoping to work on with ARMHS?

* \*Does the client have a preferred language other than English? If yes, please list below and do they need an interpreter.

Yes:  No:

* \*Are there any safety concerns Canvas Health should be aware of for this client and ARMHS Practitioners? If yes, please elaborate.

Yes:  No:

* \*Please describe the client’s mental health and substance use treatment history?

* \*Does the client have a legal guardian? If so, what is their name and contact information (email and phone number). Yes:  No:

* \*Does the Client have a Case Manager/Social Worker/Care Coordinator? If yes, please include their contact information. Yes:  No:

* Does the client have any mental health triggers Canvas Health should be aware of? If yes, please elaborate.

Yes:  No: