** 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 Washington, Hennepin, Anoka, Isanti, Chisago, 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: