A BETTER CONNECTION

1009 Hollinger Street Park Rapids, MN 56470

Mental Health Referral Form

Date: _____

First Name: _____ **Last Name:** _____

Gender: _____ **Age:** _____ **DOB:**_____

Address: _____

City: _____ **Zip Code:**_____ **County:** _____

Insurance Company:_____ **ID #**:_____

Parent/Guardian Name(s) (if under 18 years) **:**_____

Contact Phone Number: _____

Referral Source: _____ **Agency:** _____

Referral Phone: _____ **Email:** _____

ROI Attached?: Y / N

Areas of Need: _____

_____

_____

Additional Comments/Information: _____

_____

_____