FALADCARE LLC REFERRAL FORM

Personal Information

First Name:		M.I.:	Last Name:	
Date of Birth:	Gender: ☐ Male ☐ Female ☐ Prefer not to answer ☐ Other:_______________		Race:	SSN:
Address:			City:	State: **MN** Zip:
Phone Number:			Cell Number:	Work Number:

Reason(s) for Referral

☐ Counseling Services ☐ Housing Access Coordination (HAC)
☐ Relocation Services (RSC) ☐ Waiver Transportation
☐ 24-hr. Emergency Assistance - Tier: ______________________
☐ Independent Living Services - ILS Hours per Week: __________
☐ Other (specify): ____

Diagnosis (mental health and physical health) (please include diagnostic code as well as description)

Special Needs

Are there any known cultural consideration needs? ☐ Yes ☐ No specify: ______________________________

Is there any gender preference regarding the assigned staff? ☐ Yes ☐ No If yes: ☐ Male ☐ Female ☐No preference

Allergies: ____

Other (be specific): ____

Insurance Information

Primary insurance: *(please check box)* ☐ UCARE ☐ MEDICA ☐ Health Partners ☐ Blue Cross Blue Shield ☐ Straight MA ☐ Metropolitan Health Plan ☐ Other:_______________________	PMI Number: Medical Assistance Number:
Primary Ins. # Group #	Other insurance information:

Does this person have: ***(mark if known; leave blank if unknown)***

Mental Health Case Manager? ☐ Yes ☐ No **(If yes, enter information below)**

Waiver Case Manager? ☐ Yes ☐ No **(If yes, enter information below)**

Waiver Type: ☐ Brain Injury ☐ CAC ☐ CADI ☐ DD ☐ EW

Care Coordinator with primary clinic or insurance company? ☐ Yes ☐ No **(If yes, enter information below)**

Other: (***Please specify type of provider such as physician, therapist, psychiatrist, child protection worker, etc.)***

Provider Type: ____

Mental Health Case Manager Information

First Name:	Last Name:	
Address:	City:	State: **MN** Zip:
E-mail Address:		
Office number:	Office Fax:	Cell number:
Agency Name:	Would you like to be updated on all assessment scheduling & treatment of services? ☐ Yes ☐ No	

Waiver Case Manager Information

First Name:	Last Name:	
Address:	City:	State: **MN** Zip:
E-mail Address:		
Office number:	Office Fax:	Cell number:
Agency Name:	Would you like to be updated on all assessment scheduling & treatment of services? ☐ Yes ☐ No	

Care Coordinator Information

First Name:	Last Name:	
Address: City:	State: MN Zip:	
E-mail Address:		
Office number:	Office Fax:	Cell number:
Agency Name:	Would you like to be updated on all assessment scheduling & treatment of services? ☐ Yes ☐ No	

Legal Status

☐ responsible for self	☐ under guardianship **(complete box below)**	☐ under commitment

Legal Representative Contact Information

First name:	Last name:	
Address:	City:	State: MN Zip:
Best Contact Number:	Fax Number:	Email:

Primary Emergency Contact Information

First name:	Last name:
Best Contact Number:	Relationship:
Second Contact Number:	Email:

Case Manager/Other Provider Type Contact Information/Referral Source

First Name:	Last Name:
Address: City:	State: MN Zip:
E-mail Address:	

Office number:	Office Fax:	Cell number:
Agency Name:	Would you like to be updated on all assessment scheduling & treatment of services? ☐ Yes ☐ No	

Referrals and copies of documents can be mailed, faxed, or e-mailed to:

FALADCARE INC
2882 MIDDLE STREET
LITTLE CANADA, MN 55117
Fax: (651) 560-7947 Attn: EMMANUEL FALADE
E-mail: Cfaladus@gmail.com Subject: Referral Form