2575 Harvest Lane NW, P.O. Box 977, Owatonna, MN, 55060
Phone: (507) 446-0431 Fax: (651) 925-0337
Email: info@fernbrook.org

Children's Mental Health Targeted Case Management
Referral Form/Initial Intake

Please attach signed release form and copy of current diagnostic.

Eligible Child: ____ DOB: ___________ Gender: Male Female

Address (if different from below):____

Culture/Ethnicity: ________________________________ Primary Language: ______________________________

MA Number:__________________________________ SS Number:____

Mother: ___________________________________ Father:____

Address:___________________________________ ____

___________________________________ ____

Phone: ___________________________________ ____

DOB: ___________________________________ ____

Significant other:___________________________ ____

Current Diagnostic Assessment: (w/in last 180 days) Yes No

Agency ____

Phone: __________________________________ Fax: _________________________________

Axis I:____

Axis II:____

Axis III:____

Meds:____

Medical Conditions: ____

Allergies: ____

Current Household/Living Arrangement			
Name	**Age**	**Relationship**	**School/Work**

School:______________________________ Phone:______________________

Therapist:____________________________ Phone:______________________

Psychiatrist:__________________________ Clinic:______________________

Address:_____________________________ Phone:______________________

Medical Dr:___________________________ Clinic:______________________

Address:_____________________________ Phone:______________________

MA: Yes No

INS Company Name: ____

INS Address: ____

Subscriber Name: _______________________ ID Number: ___________________________

INS Company Phone: _____________________ Group Number: _________________________

Other Agencies:

Contact Name	Agency & Address	Phone
____________________	___________________________	____________
____________________	___________________________	____________
____________________	___________________________	____________

Referral Source: ____________________________ Date: ________________

Reason for Referral: