UNIVERSITY OF MINNESOTA

Community-University Health Care Center

Fax referrals to 612-301-1040

Child Case Management Referral

Name:		Date:	
SS# and PMI:		DOB:	Sex:
Street Address	City/State:	Zip:	
Phone #1:	Phone #2:	Best time to Reach:	
Insurance Company Name:		Insurance ID:	
Referred by:		Referral phone:	
Agency referring:			
Summary of problems/needs:			

This person has functional impairments in the following area(s):

☐ Symptom management	☐ Educational	☐ Self-care/ADL'S	☐ Financial
☐ Mental health services	☐ Interpersonal relations	☐ Medical	☐ Housing
☐ Alcohol/drug abuse	☐ Social/Leisure	☐ Dental	☐ Transportation
☐ Vocational	☐ Other: please specify:		

Has a psychiatric/psychological assessment been done and does this client have a SPMI/SED dx? ☐Yes ☐No
If yes, please send with referral.

Please inform your client of this referral. Client aware of referral? ☐ Yes ☐ No

Language specific staff (Non-English speaking clients please identify language so the appropriate staff can contact the client directly): _____

Do you have a release of information completed for CUHCC? ☐ Yes ☐ No **If yes, please send with referral.**

Call Jessica Kisling Mental Health Professional w/questions at: 612-301-1044. Please fax a copy of the Diagnostic Assessment w/this referral to: 612-301-1040 Attn: Jessica Kisling.