



Lotus Transitional Services L.L.C.

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Katherine's House Referral Form

Date of Referral: _____

Referral Source: _____

Contact # _____

Name of person being referred: _____
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DOB: \_\_\_\_\_

Contact # \_\_\_\_\_

Address: \_\_\_\_\_

Current living situation: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_

Member ID/Policy #: \_\_\_\_\_

Group Number: \_\_\_\_\_

Maxis #: \_\_\_\_\_  
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Reason for admission to Katherine's House: _____
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County of Residence: \_\_\_\_\_

Case Manager/Social Worker: \_\_\_\_\_

Contact #: \_\_\_\_\_

Probation Officer: \_\_\_\_\_

Contact #: \_\_\_\_\_

Legal Issues: \_\_\_\_\_  
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Current Diagnosis (medical, mental health, substance use disorder):

Chemical / Substance Use Concerns:

None

Current alcohol / drug use:

o Date of last use: _____

o Drug (s) used: _____

o Method of use: _____

Previous alcohol / drug use:

CD treatment history (when / where):

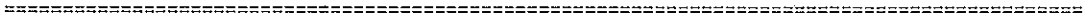
Mental Health concerns:

✓ Check all that apply:	Current (within last 30 days):	History of:
Feeling depressed, hopeless		
Feeling nervous, anxious		
Suicidal thoughts		
Suicidal plan / intent		
Homicidal thoughts		
Homicidal plan / Intent		
Hallucinations -- auditory		

Hallucinations -- visual		
Physical aggression		
Verbal aggression		
Threatening behavior		
Self-injurious behavior		
Trouble falling asleep		
Trouble staying asleep		
Sleeping more than usual		
Low energy		
Lack of interest		
Excessive energy		
Poor appetite		
Eating too much		
Trouble concentrating		
Restlessness		
Trouble relaxing		
Easily irritated		
Excessive worrying		
Feeling afraid		

Other concerns:

Mental Health Hospitalizations (when / where):



Medical concerns:

Primary Physician/ Facility: _____

Are there any health concerns /special needs:

Any communicable diseases:

=====

✓ Please include the following information with this referral:

- Current diagnostic assessment
- Last Rule 25
- Last physical

Please contact

218 -744-4040 or

Fax 218 -744-9940.

Thank-you.

Katherine's
House
