Karen Organization of Minnesota

CD Youth Case Management Referral
Fax Referrals to 651 788 7909 or email ctunwin@mnkaren.org

Referral Date:_______________

Referral from:

Name/Position:
Agency/Department:
Phone:
Fax:
Email:

Referred Participant information:

Name:	**Date of birth:**	**SSN:**
US arrival date:	**Phone Number:**	**Emergency Contact:**
Address:		
Special Accommodations (disability, language, etc.):	**List providers client is already working with:**	

Comments: *explain in detail why this client is being referred for Chemical Dependency Youth Case Management program.*

I hereby authorize the release of the above information concerning myself to the service provider listed above for the purpose of providing the requested services. I understand that I may revoke this consent in writing. I also understand that without this information the agencies listed above may be unable to provide me or my dependents with the services I am requesting. A photocopy of this authorization will be treated in the same manner as the original.

Client Signature: ____ **Date:** _______________________________

Parent or Guardian Signature (for minors): _____________________________ **Relationship to client:** _________________

Karen Organization of Minnesota | 2353 Rice Street, Ste. 240 | Roseville, MN 55113 | Phone: 651-788-7593 | Fax: 651-788-7909

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