**Refugee Mental Health Services**

**Initial Screening Referral**

Participant/Refugee Name:  Date of Birth:

Race/Ethnicity:

Primary Language(s):

English Proficiency:  none  some  good  fluent

Date of Arrival:

Alien #:

Address:

Phone Number:

**FROM:**  RICS/ Heartland  World Relief- Chicago

Catholic Charities  Refugee One

Refugee Health Program  Ethiopian Community Association Chicago

Pan African  Other agency :

Staff Contact:       Date:

Staff Phone/Email:

**TO:** IFACES

Reason(s) for referral:

Attachments (please attach as many as you have):

Release of Information (required)

Copy of I-94

Copy of Medicaid card / insurance information

Copy of Social Security Card

Relevant Prior Treatment Information

Relevant Screening Tool (such as RHS-15)

Please return this form to International FACES staff

Amy Dix, Clinical Supervisor

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