**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:** [x] 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

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