



MENTAL HEALTH REFERRAL FORM
 Please print legibly – fax *completed* form to
 Vera French Intake Dept. at 563.823.0761

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
 Address: _____ Gender: M F
 _____ Primary Phone: _____
 S.S. #: _____ Alternate Phone: _____
 Agency Involved: _____
 Parent / Foster Parent / Legal Guardian Name (if patient is dependent): _____
 Parent S.S. #: _____ Parent Date of Birth: _____

FINANCIAL / INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____
 Policy #: _____ Group #: _____
 Name of Insured: _____ Ins. Date of Birth: _____
 Secondary Insurance: _____ Phone: _____
 Policy #: _____ Group #: _____
 Name of Insured: _____ Ins. Date of Birth: _____
 Iowa Medicaid Status (circle, if applicable): Current Eligible Application Pending Has Not Applied

REFERRAL SOURCE

Referred by: _____ NPI #: _____
 Address: _____ Office Phone: _____
 _____ Office Fax: _____
 Contact Person: _____ Is Patient Aware of Referral? YES NO

Patient Name: _____

REASON FOR REFERRAL

Reason for Request: _____

Diagnostic Impression:

<input type="checkbox"/> Mood Disorder	<input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Adjustment Disorder
<input type="checkbox"/> Psychosis	<input type="checkbox"/> Behavioral Disorder	<input type="checkbox"/> Marital Issues
<input type="checkbox"/> Anxiety / PTSD	<input type="checkbox"/> Parenting Issues	<input type="checkbox"/> Personality Disorder
<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Violent Behavior	<input type="checkbox"/> Self-Injurious Behavior
<input type="checkbox"/> Other (please explain)		

Referral Source is Requesting:

<input type="checkbox"/> Therapy	<input type="checkbox"/> Consult Only (circle one): Psychiatrist or Therapist
<input type="checkbox"/> Medication Management	<input type="checkbox"/> Consult and Treat (circle one): Psychiatrist or Therapist
<input type="checkbox"/> Behavior Management	<input type="checkbox"/> Other (please explain):

HEALTH HISTORY

Please list current medications or you may attach a list of current & past medications:

Medication	Dose	Frequency	Effect

Medical History:

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies (please list)
<input type="checkbox"/>	<input type="checkbox"/>	Head Trauma, Developmental Disability, Seizure Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Renal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Metabolic Disease
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Immunological Disease

VF Office Use Only:

- Patient Intake Appt. scheduled for: _____
- Patient placed on Cancellation List
- Patient not scheduled for the following reason: Unable to Contact Patient Declined Services