VERA FRENCH

Integrated Health Program - Referral Form

Referring Person: ______________________________ Referring Agency/Institution/Self: ____________________________

Telephone: ______________________ Fax: _________________________ Email: __________________________________

Date of Referral: ______________________ IHP Staff Working Enrollment: ________________________________

Adult IHP Referral ☐ Pediatric IHP Referral ☐

Person must have full Medicaid or Iowa Health & Wellness and qualify to be medically exempt in order to be eligible for Integrated Health.

Name: __________________________________ DOB _____________________ Medicaid # _________________________

Address: ____

City: _________________________ State: __________Zip: ________________Telephone: __________________________

Does referral have a guardian/parent responsible for Health Care? *Yes ☐ No ☐

*If yes: Guardian/Parent Name(s): ____

Address: ____

City: _________________________ State: __________Zip: ________________Telephone: __________________________

Is the member on a waiver? No ☐ Yes ☐ Unknown ☐

Primary care provider: ____ Telephone: __________________________

Group Practice Name: ____

Psychiatric Provider: ____ Telephone: (if not VF) __________________

MH Diagnosis:

Submit referral form and ***any additional information supporting MH diagnostics and/or presenting problems*** *to*:

Vera French Community Mental Health Center
ATTN: Integrated Health Programs
1441 W. Central Park Avenue
Davenport, Iowa 52804 Email to: IHP@verafrenchmhc.org Fax to: 563.823.0761

Date Received/Staff Initials: _____________________________ Date referral source was notified of disposition: ___________________________

Disposition of referral: ☐ Enrolled ☐ *Not Enrolled *State reason: Declined [ ] Not Eligible [ ] Unable to contact after minimum of 3 attempts [ ]

Date of Data Entry in NextGen (***if enrolled and/or a current patient***) _______________________________

Date of Data Entry in ACCESS DataBase (***for all Referrals)***: ____

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