VERA FRENCH

Integrated Health Program - Referral Form

REFERRAL

Referring Person: Date of Referral: _____

Adult IHP Referral ☐ Pediatric IHP Referral ☐ New Patient or Established Patient (circle one)

Hospital Admit Date: _____ Anticipated Discharge Date: _____

Hospital Name/Location: _____

Prescribers Name: _____ Date/time of Appt: _____

Person being referred to IHP must have Medicaid (MBC) or Iowa Health and Wellness

Name: _____ DOB _____ Medicaid # _____

Address: _____

Telephone: _____ Alternate Telephone: _____

Primary MH Diagnoses: _____

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

Guardian/Parent Names: _____ Telephone: _____

Please send to Heather Hinton, BA at Vera French CMHC 563/823-0221 (fax) or hintonh@verafrenchmhc.org (email) Questions: Heather Hinton BA 563/888-6229

IHP STAFF ONLY BELOW THIS LINE

Date Received by IHP: _____ Staff Assigned: _____

IHP Engagement attempts and summary of engagement must be documented in EHR.

If contact was made, is person planning to keep their appointment? [ ] YES [ ] NO (**if no, notify Cody immediately**)

If Yes, Method of transportation? _____

MUST offer transportation to appointment if member seems unsure of how they will get here.

[ ] Scheduled Enrollment Date/Time: _____ [} Declined or ineligible (reason)