VERA FRENCH

Integrated Health Program - Referral Form

REFERRAL

Referred by:____________________ Date of Referral:___________________

Address: ____

Office Phone Number:______________________ Contact Person:____________________________

Prescribers Name:__________________ Date/time of next scheduled appointment:______________________

Person being referred to IHH must have Iowa Medicaid

Adult IHP Referral ☐ Pediatric IHP Referral ☐

New Patient ☐ Established Patient ☐

Name:_____________________ Date of Birth:_________________ Medicaid Number:________________

Address: ____

Phone Number:__________________________ Alternate Phone Number:___________________________

Mental Health Diagnoses:____

Does Referral have a Guardian or Parent responsible for Health Care? Yes ☐ No ☐

Guardian/Parent Names:____________________________ Telephone:___________________________

Please send to Jamie Nowlin & Ashley Cole

Fax: (563) 823-0221

Email: nowlinj@verafrenchmhc.org & colea@verafrenchmhc.org

Phone: (563) 888-6229 or (563)888-6237

For Internal Use Only

Date Processed by IHH:_________________

Able to contact Referral by Phone: Yes ☐ No ☐

Note made in EHR regarding Referral Status: Yes ☐ No ☐