VERA FRENCH
Mental Health for Healthy Living

Program Referral Form

To be completed and emailed or faxed to referralpt@verafrenchmhc.org or 563-888-8629.
For referral questions, please call 563-383-1900, option 2.

Today's Date:_____

Patient Information

Last Name:	First:	Middle:		☐ Mr. ☐ Mrs. ☐ Ms.
Birth date:	Social Security #:	Sex: ☐ F ☐ M	Phone #:	
			Alternate Ph #:	
Address:				
City:	State:	Zip Code:		

Insurance Information

Is this patient covered by insurance? ☐ Yes ☐ No		Primary Insurance:		
Subscriber's Name:	Subscriber's SS #:	Birth date:	Group #:	Policy #:
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Patient Needs:

☐ Mental Health Services	☐ Substance Abuse Services	☐ Co-Occurring Services (Both Mental Health and Substance Abuse)

Select a Program:

☐ Assertive Community Treatment (ACT)	☐ Recovery Community Center	☐ Community Based Peer Support	☐ Community Support Services (CSS)
☐ Habilitation Homes	☐ Homeless Outreach	☐ Individual Counseling/Therapy	☐ Individual Placement & Support (IPS)
☐ Multisystemic Therapy (MST)	☐ Outpatient Substance Use Disorder	☐ Overdose Prevention	☐ Prescriber Services
☐ Residential Care Facilities (RCF)	☐ Rick's Ray of Hope (RROH)	☐ School & Community-Based Services	☐ Supported Community Living (SCL)
☐ Other:			

Referral Source (if applicable)

Name of facility:	Referred by:
Complete Address:	
Office Phone #:	Office Fax #:
Contact Person:	