

REFERRAL FORM



DATE OF REFERRAL ____/____/____

PLEASE INCLUDE THE FOLLOWING WITH REFERRAL: ANY PREVIOUS PSYCHOLOGICAL, PSYCHOSOCIAL, MEDICAL/ PPD (CURRENT), COPY OF INSURANCE CARD(S) AND ISP.

IS TRANSPORTATION MEDICALLY NECESSARY? YES NO

DOES THE INDIVIDUAL USE A WHEELCHAIR? YES NO FOR SCHEDULING PLEASE CONTACT _____

WILL SOMEONE ACCOMPANY THE INDIVIDUAL? YES NO PHONE _____

FIRST NAME _____ LAST NAME _____ DOB _____ SEX _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TYPE OF RESIDENCE FAMILY ICF IRA CR OTHER _____

HOME PHONE _____ PARENT/GUARDIAN _____

EMERGENCY CONTACT _____ PHONE _____ CELL _____

SS# _____ MEDICARE # _____ MEDICAID # _____

OTHER INSURANCE / TYPE _____ NO INSURANCE

PRIMARY DIAGNOSIS _____ LEVEL OF MR _____

LANGUAGE SPOKEN ENGLISH SPANISH OTHER _____

DAY SERVICE PROVIDER / EMPLOYER _____ IS THIS A DAY TREATMENT PROGRAM? YES NO

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____ PROGRAM DIRECTOR _____

DOES THE INDIVIDUAL ATTEND ANY OTHER ARTICLE 16 CLINICS? NO YES IF YES, PLEASE COMPLETE:

PROVIDER'S NAME _____ TYPE OF CLINIC _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____ CONTACT PERSON _____

CURRENT MEDICATION AND DOSAGE _____

ALLERGIES _____ SPECIAL ALERTS _____

SERVICE(S) REQUESTED CHECK ALL THAT APPLY.

PHYSICAL THERAPY OCCUPATIONAL THERAPY PSYCHO THERAPY

SPEECH THERAPY PSYCHOSEXUAL COUNSELING GROUP THERAPY

PSYCHOLOGICAL EVALUATION UPDATE COMPREHENSIVE

PSYCHOSOCIAL EVALUATION UPDATE COMPREHENSIVE

PSYCHOSEXUAL EVALUATION

REASON FOR REFERRAL (PRESENTING PROBLEM)

SOURCE OF REFERRAL (NAME) _____ AGENCY _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

E-MAIL ADDRESS _____ RELATIONSHIP _____

SEND REPORT(S) TO REFERRAL SOURCE SERVICE COORDINATOR OTHER _____

IS THE PRIMARY CAREGIVER AND INDIVIDUAL IN AGREEMENT WITH THIS REFERRAL? YES NO IF NO, ATTACH EXPLANATION

IS THE SERVICE COORDINATOR IN AGREEMENT WITH THIS REFERRAL? YES NO

OFFICE USE ONLY

PRESCRIPTION FOR SERVICES: AFTER REVIEW OF THIS INFORMATION, IT IS MY PROFESSIONAL MEDICAL OPINION THAT THIS INDIVIDUAL SUFFICIENTLY MEETS ALL ADMISSION CRITERIA TO RECEIVE SERVICES PROVIDED BY HEARTSHARE WELLNESS ARTICLE 16 CLINIC. THIS AUTHORIZES THE PERFORMANCE OF CLINICAL EVALUATIONS NECESSARY TO DEVELOP A TREATMENT PLAN.

MEDICAL DIRECTOR SIGNATURE

DATE

TREATMENT COORDINATOR ASSIGNED _____