INTEGRATED HEALTH PROGRAM REFERRAL FORM

Developing Strong Futures
Orchard Place

REFERRING ORGANIZATION INFORMATION (If Applicable)

Referring Organization	Date
Referring Staff	Phone
Other Referral Source	Phone

INSURANCE INFORMATION

○ Amerigroup ○ Iowa Total Care ○ Other (IME)	Medicaid Number
Private Insurance	Policy Number

MENTAL HEALTH INFORMATION

Current Waiver(s) (if applicable)	Child's Mental Health Diagnosis
Current Mental Health Provider(s)	

CLIENT INFORMATION

Child's Name	Date of Birth
Child's Address	Gender ○ Female ○ Male
	Phone
Mother's Name	○ Custodial ○ Non-Custodial
Address	
Phone	Email
Father's Name	○ Custodial ○ Non-Custodial
Address	
Phone	Email
Legal Guardian	○ Custodial ○ Non-Custodial
Address	
Phone	Email
Primary Language	

Additional Information (Please indicate current providers, immediate referral and resource needs, etc.)

Please return this form to ihp@orchardplace.org or fax at (515) 697-5701