

Hillcrest Family Services  
Community Services Referral Form  
220 W. 7<sup>th</sup> Street  
Dubuque, Iowa 52001  
563-588-0605

REFERRAL DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

FULL NAME: \_\_\_\_\_

SS#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE # \_\_\_\_\_

LEGAL STATUS: \_\_\_\_\_

INS. TYPE & NUMBER: \_\_\_\_\_  
\_\_\_\_\_

STATE CASE: Y \_\_\_\_\_ N \_\_\_\_\_

DHS CASE MGR/SW NAME (if applicable): \_\_\_\_\_

CO. OF LEGAL SETTLEMENT \_\_\_\_\_

DIAGNOSIS (IDENTIFY DIAGNOSIS AND CODE #) :

AXIS I: (Primary) \_\_\_\_\_

AXIS II: (Secondary) \_\_\_\_\_

AXIS III: \_\_\_\_\_

AXIS IV: \_\_\_\_\_

AXIS V:      CURRENT GAF \_\_\_\_\_      HIGHEST GAF PAST YEAR \_\_\_\_\_

AREA OF SERVICE BEING REFERRED TO:

\_\_\_\_\_ SUPPORTED COMMUNITY LIVING

\_\_\_\_\_ VOCATIONAL PROGRAM

\_\_\_\_\_ INTENSIVE PSYCHIATRIC REHABILITATION (IPR)

\_\_\_\_\_ HOMELESS OUTREACH PROGRAM - please call Homeless Outreach Counselor for immediate assistance 451-2021

\_\_\_\_\_ WELLNESS CENTER

\_\_\_\_\_ WELLNESS CENTER/PEER SUPPORT SERVICES - MUST BE T19/MAGELLAN ELIGIBLE

REASON FOR REFERRAL/PRESENTING PROBLEM: \_\_\_\_\_  
\_\_\_\_\_

---

---

ALLERGIES: \_\_\_\_\_

CURRENT MEDICATION ORDERS: \_\_\_\_\_

---

---

PHYSICAL LIMITATIONS/ MEDICAL CONDITIONS: \_\_\_\_\_

---

SUBSTANCE ABUSE ISSUES: \_\_\_\_\_

---

HOSPITALIZATIONS IN PAST YEAR: \_\_\_\_\_

---

ANY CURRENT SUICIDAL/HOMICIDAL IDEATION: \_\_\_\_\_

---

---

ANY OTHER SERVICES PERSON IS RECEIVING CURRENTLY: \_\_\_\_\_

---

OTHER PERTINENT INFO: \_\_\_\_\_

---

---

CLINICIAN NAME: \_\_\_\_\_

PHONE/EXT: \_\_\_\_\_

PSYCHIATRIST NAME: \_\_\_\_\_

PHONE/EXT: \_\_\_\_\_

\_\_\_\_\_  
Referral Name/Signature

\_\_\_\_\_  
Date

Please direct all referrals to the Community Services Program Manager:  
220 West 7<sup>th</sup> Street  
Dubuque, Iowa 52001  
563-588-0605 FAX 557-4447- this form can be faxed