

Hillcrest Family Services - Community Services Referral Form
449 Hwy 1 West Iowa City, Iowa 52246 319-337-4204
4080 1st Ave SE Suite 102A Cedar Rapids, Iowa 52043 319-362-3149

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- Iowa City

_____ SUPPORTED COMMUNITY LIVING- Cedar Rapids

_____ PAYEE- Through HAB Waiver in Cedar Rapids and Iowa City

_____ IN-HOME PSYCHIATRIC NURSING SERVICES- *Iowa City residents who are Magellan
Medicaid eligible consumers only*

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 SOURCE: _____

PHONE/EXT: _____

Signature

Date