Southern Iowa Mental Health Center
Where recovery happens!

SIMHC ACT Referral Form:

Date of Referral: _____

Referral Source Name and Contact Information: _____

_____

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____

Street City State Zip Code

Patient Phone Number: _____ Patient Guardian Name: _____

Funding Region: _____ Case Manager: _____

Income/Benefits/Amount/Frequency: _____

Medicaid/MCO: _____ Medicaid Number: _____

Current Mental Health Provider: _____ **(Please attach records if able)**

Current Medications (Dose/Frequency/Prescriber): _____

_____

_____

_____

_____

_____

Diagnosis: (Please list all psychiatric and medical conditions) : _____

_____

_____

_____

_____

Recent hospitalizations; frequency, location, reason, etc.: _____

_____

_____

_____

_____

Services utilized in past two years (visiting nurses, counselors, in home supports, residential care, etc.): _____

_____

_____

_____

Reason for referral: What will the patient get from ACT: _____

_____

_____

_____

Please send referral form to: Lorri Gire, LISW at LGire@SimhcOttumwa.org or fax 641-682-1924