Southern Iowa Mental Health Center
Where recovery happens

INTEGRATED HEALTH HOME – Referral Form

Date: _____ Referral Source (Name): _____ Referral Source Contact: _____

Client FULL Name: _____ Date of Birth/Age: _____

Gender: ☐ Male ☐ Female Medicaid #: _____

Legal Status: _____ Responsible Party Name: _____

Relationship to Client: _____ Responsible Party Contact: _____

After Care Status (Was client referred from a psychiatric inpatient or residential facility?): ☐ Yes ☐ No

If so, from where?: _____

Client Address: _____
Mailing Address City State Zip

Client Phone Number: _____ Can we leave a message? ☐ Yes ☐ No

How should we identify our office? _____
(ie: Integrated Health Home, IHH, Mental Health Center etc.)

Please check all known **current** service(s) and list provider location:

☐ Outpatient Psychotherapy _____

☐ Outpatient Psychiatric (Med Management) _____

☐ Community Services (IPR, **HAB**, CSS, SCL, etc.); Please designate which one(s): _____

☐ Waiver Services (ID, PD, IH, E, BI, AIDS/HIV, **CMH**); Please designate which one(s): _____

☐ In-Home Services (BHIS, In-Home Health Care, etc.): _____

☐ Other _____

Current Need/Brief History:

_____

_____

Does client need a HAB Assessment? ☐ Yes ☐ No

FORM CAN BE RETURNED TO: SIMHC 1527 Albia Road, OTTUMWA, IA 52501 * 641-682-1924 (FAX) * Simhc@SimhcOttumwa.org