Date of Referral: _____

Referral Form

Integrated Behavioral Health Services

1430 South St., Ste 110, Lincoln Nebraska 68502
Phone: 531-500-4429 Fax: 1-402-939-0734
Email: Info@IBHealthservices.com

Programs Referred to:
- ☐ **Community Support Services**
- ☐ **Day Psychiatric Rehabilitation**
- ☐ **Outpatient MH Services**
- ☐ **Psychiatric Residential Rehabilitation**

Legal Name:			
Address:		**City/Zip:**	
Home Phone:		**Cell Phone:**	
Guardian:		**Guardian Phone:**	

Social Security Number:		**Date of Birth:**	
Preferred Language:		**Gender:**	

Does the consumer have Medicaid?	☐No ☐Yes, provide # if known:	

Primary Diagnosis:		**Clinician:**	
Other Diagnosis:			
Medical:			
Medications:			
Functional Deficits:	☐ Primary Support Group ☐ Social ☐ Occupational	☐ Education Problems ☐ Access to Health Services ☐ Economic	☐ Legal ☐ Housing ☐ Other
Allergies:			

Reason for referral:	
Presenting Problems/Immediate Needs:	

Is the individual aware of the referral?	☐Yes ☐No, explain below:

Please include the following documents (if available):
- ☐ Latest Psychiatric Evaluation or Psychological Evaluation
- ☐ List of Medications
- ☐ Release of Information to current psychiatrist and/or therapist
- ☐ Release of Information to pharmacy if list of medications is not available

Referring Agency:			
Contact Person:		**Phone:**	

Administrative Use Only:
- ☐ **Approved for services**
- ☐ **Does not meet criteria.**

Reason:
_____
_____