INTEGRATED BEHAVIORAL HEALTH SERVICES

PSYCHIATRIC RESIDENTIAL REHABILITATION PROGRAMS

Secure Residential

Leggiadro Center for Growth and Development

Main Office: 531.500.4429

Please submit all referral documents to IBHS via the referral email. Thank you!

EMAIL TO REFERRALS@IBHEALTHSERVICES.COM

Referral must be completed in it's entirety to be reviewed for eligibility

REFERRAL INFORMATION

Referring Agency:	Date of Referral:
Referral Contact:	Date of Intake at Referring Agency:
Referral Phone Number:	Email:
Contributing factors leading to referral?	

PATIENT INFORMATION

Legal Name:	Gender:		Preferred Pronouns:
Date of Birth:	Age:	Preferred Language:	
Social Security Number:	Occupation:		Region:
Marital Status:	Highest Level of Education:		Ethnicity:
Permanent Address:		Wanting to return to current living situation	

CONTACT INFORMATION

Guardian	Payee	Conservator	Self
Name of Guardian/Payee:		Relationship to Patient:	
Address:		Phone Number:	
		Alternative Number:	
Email Address:		Preferred route to Contact:	

****Attach ALL Guardianship/Payee/Conservator Paperwork to referral****

Emergency Contact:	Phone Number:
We will notify this person in case of an emergency	Alternative Phone Number:

MENTAL HEALTH BOARD COMMITTMENT / LEGAL

	No Mental Health Board Committment		Current Probation Status
	Current Mental Health Board Committment		Pending Charges
County of Committment:			Illegal Sexual Acts
Case Number:			Sexual Offender Registration
Last MHB Hearing Date:			Previous Felony Charges
NRRI Status:			Active Warrants

INSURANCE/BENEFIT INFORMATION

Medicaid	UHC	Social Security Benefits (SS) $
Medicare	NTC	Social Security Income (SSI) $
Dual Complete Plan	HEALTHY BLUE	Aide to Aged, Blind and Disabled (AABD) $
Private Pay	Additional Coverage	Other Sources of Income
VA Benefits	Supplemental	Region Billed for Services: Room and Board or Treatment

How are funds received? (Card, Direct Deposit, Check)

POLICY INFORMATION	POLICY INFORMATION	Additional Policies
Company Name:	Company Name:	

Policy Number:		Policy Number:		
Member Number: Received		Member Number: Lab Results		Attach all current Insurance Card copies and Benefit Award Letters regarding income sources
	Active		Active	
Activation Date:		Activation Date:		
	Not Active		Not Active	

MENTAL HEALTH INFORMATION

Current Diagnosis:	
	Acts of suicide attempts in last 30 days
	Acts of self harm in last 30 days
	Any Restraint in last 30 days
	Medication Compliance in last 30 days
	Aggression/Assaults within the past 90 days

SUBSTANCE USE HISTORY

	Substance Use History
Substance 1:	
Substance 2:	
Substance 3:	
Additional Comments:	
	Nicotine Dependency

MEDICAL HEALTH INFORMATION

Medical Conditions:			
Drug Allergies	Diabetes	Mobility Concerns	Scheduled Injection
Food Allergies	Heart Disease	Physical Injuries	Frequency:
Enviromental Allergies	Pregnant	Memory Concerns	Date of Last:
Medication Efficacy:			
List Allergies/Reactions:			
Current Providers:			
Upcoming/Scheduled Appointments:			

Provide Current Lab work (within at least 6 months of referral date)

FAMILY HISTORY

Has anyone in your family had any of the following?	
Major Mental Illness	Relationship:
Incarceration	Relationship:
Substance Abuse	Relationship:
Criminal Involvement	Relationship:
Military Service	Relationship:

SUPPORTS

Primary Supports:
No assistance for bathing
No assistance for dressing
Assistance needed for money management

PREVIOUS TREATMENT HISTORY

Previous Treatment ***(Mental Health, Substance Use, Outpatient, Therapy, Detox):***

OFFICE USE ONLY

Ineligible for Services		Waitlisted/Date:
Denied for Services		Verification/Support Docs
Eligible for Services	Date of Interview:	Medicaid Active
Approved for Services	Offered Date of Admission:	Region Billed

Received Personal Belonging Acknowledgment	Medication List Received	Lab Results Received