Hillcrest Family Services
Community Services Referral Form
220 W. 7th Street
Dubuque, Iowa 52001
563-588-0605

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

_____VOCATIONAL PROGRAM

_____INTENSIVE PSYCHIATRIC REHABILITATION (IPR)

_____HOMELESS OUTREACH PROGRAM-please call Homeless Outreach Counselor for immediate assistance 451-2021

_____WELLNESS CENTER

_____WELLNESS CENTER/PEER SUPPORT SERVICES- MUST BE T19/MAGELLAN ELIGIBLE

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 Name/Signature Date

Please direct all referrals to the Community Services Program Manager:
220 West 7th Street
Dubuque, Iowa 52001
563-588-0605 FAX 557-4447- this form can be faxed