**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) dgdfgdfg _____

AXIS II: (Secondary) dfgdfg _____

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)

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:_____

REFFERAL SOURCE:_____ PHONE/EXT:_____

_____ _____

Signature Date