REGION II HUMAN SERVICES CLIENT REFERRAL SHEET

Date: _____ Initial Contact: _____ Phone Walk –In
(Client, Physician, Parent, Probation, etc.)

Client Name: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Male Female

Address: _____ City: _____ State: ____ Zip Code:_____

Phone: _____ Cell/Alternate Phone: _____

Employed at: _____ Work Phone: _____ Occupation: _____

If Client is a Child:

Parent/Guardian/Foster Parent Names:_____

Parent(s) Employer: _____ Phone:_____

School attending: _____ Grade: _____

State Ward?: _____ Case Worker: _____

Referred by: _____ Phone: _____ EAP ? Yes No

Referring Provider NPI # _____

Has client or family member received any services previously from Region II/Heartland? Yes No
If yes, explain: _____

Presenting Problem and Services Requested

_____

_____

_____

Insurance Information:

Primary Insurance _____ ID#: _____

Secondary Insurance_____ ID#: _____

EAP Referral? No Yes Contracted Fee _____

Medicare? No Yes #_____ Part A , Part B, Part D (Circle all that apply)

Medicaid? No Yes #_____ Managed Care? No Yes

Authorizations:_____

_____

Client informed of Cost: Yes No Income Verification: _____

_____

TO HELP US SERVE YOU AND OTHERS AS EFFICIENTLY AS POSSIBLE, PLEASE TELL US WHICH OF THE CHOICES BELOW CORRESPONDS WITH THE LEVEL OF URGENCY FOR YOUR APPOINTMENT:

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Emergency	**Can wait for a short period of time (two to four weeks)**
As soon as possible	**No hurry, whenever possible**

	Day	Date	Time	Staff	Service		
Appointments Scheduled:	_____	_____	_____	_____	_____	CX	NS
Appointments Scheduled:	_____	_____	_____	_____	_____	CX	NS
Appointments Scheduled:	_____	_____	_____	_____	_____	CX	NS
Appointments Scheduled:	_____	_____	_____	_____	_____	CX	NS

Comments:_____

_____

_____

Staff Signature: _____ Date:_____