
Integrated Health Team Referral Form

| **Patient Information** | | |
|---|---|---|
| Name: | | Date: |
| DOB: | Phone Number: | |
| Current Address: | | City: |
| Diagnosis:<br><br>***ATTACH PROOF OF DIAGNOSIS** | Diagnosing Provider: | |
| **Referring Agency Information** | | |
| Referring Person Name: | | |
| Referring Person Signature (credentials included, if applicable): | | |
| Agency: | | Phone: |
| Client's Current Status:<br>How urgent is the IHT contact? | | |
| Medicaid ID# | AG ☐ UHC ☐ IME ☐ MCO # | |
| Medically Exempt Attestation Forms completed if necessary: | Yes ☐ | No ☐ |
| **IHT OFFICE USE ONLY** | | |
| Date Referral Received: | | |
| Is the patient Medicaid eligible? (Include Medicaid plan type) | Yes ☐ | No ☐ |
| Staff Assigned: | | |
| Date Assigned: | | |

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