PRAIRIE RIDGE
Integrated Behavioral Healthcare

Assertive Community Treatment Referral Form

Patient Information		
Name:		Date:
DOB:	Phone#:	
Current Address:		City:
Primary Mental Health Diagnosis:	☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Bipolar Disorder (Severe and Recurrent) ☐ Major Depressive Disorder (Severe and Recurrent) ☐ Other:	
Significant Functional Impairment (Please Explain):	Daily Tasks of Adult Functioning:	
	Difficulty Maintaining Employment:	
	Difficulty Maintaining Safe Living Situation:	
High cost/ treatment failure in traditional services:	☐ Two or more inpatient admissions in past 24 months ☐ Greater than 3 weeks of hospitalization in the past 12 months ☐ Greater than 3 months of residential care in the past 12 months ☐ Decompensation or high risk of decompensation with traditional treatment due to treatment noncompliance or severe life stress	
Patient Residence:	☐ Resides within 25 miles of Prairie Ridge, Mason City	
Iowa Medicaid	Amerigroup # Iowa Total Care #	
Psychiatrist: Primary Care Provider:	Physical Health Conditions or Diagnosis:	
Current Medications	Dosage	
Services utilized in past 2 years (therapists, in-home services, residential care):		
Psychiatric hospitalizations in past 2 years ____ Days ____ Weeks	Incarcerations in past 2 years: ____ Days ____ Weeks	
Referral Source:	Phone Number:	Email Address:

Please return completed forms to: ACTreferral@PrairieRidge.net
Phone: 641-243-7297
Fax: 641-424-0783