PRAIRIE RIDGE
Integrated Behavioral Healthcare

Renew Program Referral Form

Patient Information			
Name:			Date:
DOB:	Phone#:		
Current Address:		City:	
When psychotic symptoms were first noticed:	☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Schizophreniform Disorder ☐ Psychotic Disorder ☐ Brief Psychotic Disorder		
Description of current symptoms:	Daily Tasks of Functioning:		
	Difficulty Maintaining Education/Employment:		
	Difficulty Maintaining Safe Living Situation:		
Significant Functional Impairment (Please Explain):	☐ 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		
Psychiatrist: Primary Care Provider:	Physical Health Conditions or Diagnosis:		
Current Medications	Dosage		
Incarcerations in past 2 years: _____days _____weeks			
Services utilized in past 2 years (therapists, in-home services, residential care):			
Referral Source:	Phone Number:	Email Address:	

Please return completed forms to: renewreferral@PrairieRidge.net
Phone 641-548-6135
Fax: 641-243-7263