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| --- |
| **Patient Information** |
| Name:  | Date:  |
| DOB:  | Phone#:  | SS#: |
| Current Address:  | City: |
| Diagnosis: **\*ATTACH PROOF OF DIAGNOSIS AND FULLY EXECUTED RELEASE OF INFORMATION FOR DIAGNOSING PROVIDER** | Diagnosing Provider:  |
| Do they have a guardian?Yes [ ]  No [ ]   | If yes, Guardian Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Guardian Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Referring Agency Information** |
| Referring Person Name:  |
| Agency:  | Phone:  |
| Currently employed?Yes [ ]  No [ ]  Interested in working?Yes [ ]  No [ ]   |  Reason for referral: |
| Medicaid ID#  |  AG [ ]  IA Total Care [ ]  IME [ ]  MCO #  |
| **IHT OFFICE USE ONLY** |
| Date Referral Received: |  |
| Is the patient Medicaid eligible?(Include Medicaid plan type) | Yes [ ]  | No [ ]  |
| Medically Exempt Attestation Forms completed if necessary: | Yes [ ]  | No [ ]   |
| Staff Assigned: |  |
| Date Assigned: |  |