|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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: | |  | | | | |