# **Pediatric Integrated Health**

**Referral Form**

|  |  |
| --- | --- |
| [LSI](http://mylsi/)  **Pediatric IHH** | Phone: 319-233-3579  Fax: 319-233-6569  Website: [www.lsiowa.org](http://www.lsiowa.org)  Email: [PIHHintake@lsiowa.org](mailto:PIHHintake@lsiowa.org) |

|  |  |  |
| --- | --- | --- |
| Client Name (First Middle Last): | Gender:  M  F | Date of Birth: |
| Title 19 #: | MCO Group | MCO Group # |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Contact Name: | Secondary Contact Name: | | | |
| Relationship to Client: | Secondary Phone | | | |
| Main Phone: |  | | | |
| Street Address: | City: | | State: | Zip Code: |
|  |  | | | |
| Legal Guardian (if different from above): | Relationship to Client (if different from above): | | | |
| Legal Guardian Phone: | Secondary Phone/Contact Name: | | | |
|  |  | | | |
| Referral Name: | Referral Phone: | | | |
| Referral E-Mail: | Referral Fax: | | | |
| Street Address: | City: | State: | | Zip Code: |

|  |  |  |
| --- | --- | --- |
| Are there emotional and/or behavioral issues that impact any area of the client’s life? Please check all areas that apply:  Community  Yes  No  School  Yes  No  Work  Yes  No  Home  Yes  No  Other:  Yes  No | Mental Health Diagnosis:  Yes  No | |
| Signature Parent/Guardian | Date | Email (optional) |