# **Pediatric Integrated Health**

 **Referral Form**

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

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

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| --- | --- |
| 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: |

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| 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) |