INTEGRATED HEALTH PROGRAM REFERRAL FORM

Developing Strong Futures
Orchard Place

REFERRING ORGANIZATION INFORMATION

Referring Organization	Date
Referring Staff	Phone
Other Referral Source	Phone

INSURANCE INFORMATION

■ Amerigroup ■ United Health Care	Medicaid Number
State Funded Insurance	Policy Number
Private Insurance	Policy Number

MENTAL HEALTH INFORMATION

Child's Mental Health Diagnosis	Child's Challenging Behaviors
Current Waiver(s)	

CLIENT INFORMATION

Child's Name	Date of Birth
Child's Address	Gender ■ Female ■ Male
	Phone
Mother's Name	■ Custodial ■ Non-Custodial
Address	
Phone	Email
Father's Name	■ Custodial ■ Non-Custodial
Address	
Phone	Email
Legal Guardian	■ Custodial ■ Non-Custodial
Address	
Phone	Email
Primary Language	
Additional Information (Please indicate current providers, immediate referral and resource needs, etc.)	