ZION INTEGRATED BEHAVIORAL HEALTH SERVICES
INTEGRATED HEALTH PROGRAM

2307 Olive Street
Atlantic, Iowa 50022
(712) 243-2606 Fax: (712) 243-2688

REFERRAL/TRANSFER FORM

Date: ______________

Client Name: ____

DOB:________________ Gender: M F Phone:_______ ___________________________

Address: ___________________________________ County:______________________

Medicaid #:________________ MCO:______________ Amerigroup ID:_________________

Is this person a minor? Y N If yes, who is the contact person and their phone number?
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Areas of Need:

Work/School ADLs/Independent living skills Health
Behavioral issues at home/school Housing Hygiene
Recreational activities Legal matters Financial concerns
Parenting Issues Peer support Accessing community resources
Other: ________________________________

Diagnosis:

Major Depression Schizophrenia/Schizoaffective Disorder Bipolar Disorder Anxiety

Substance Abuse Violent Behaviors OCD ADHD ODD RAD PTSD

Disruptive Behavior Autism Personality Disorder Intellectual Disability

Other: ________________________

Committed: Yes_____ No _____ If committed, which county? _________________

Guardian: Yes_____ No _____

Guardian Name and Contact Information:

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Medication Provider and Contact Information:

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