CENTRAL IOWA COMMUNITY SERVICES REFERRAL FORM

Date:		Name:		Male	☐	Female	☐
D.O.B.		State ID#:		Social Security #:			
Address:				Home Phone:			
City/State/Zip:				Work Phone:			

Guardian/Parent Name(s), if applicable:			
Address:		Home Phone:	
City/State/Zip:		Work Phone:	

Diagnosis:

Intellectual Disability	☐	Specify	
Mental Illness	☐	Specify	
Developmental Disability	☐	Specify	
Brain Injury	☐	Specify	
Other	☐	Specify	

Services Needed:

☐	Mental Health	☐	Behavioral	☐	Substance Abuse
☐	Housing/ Placement	☐	Vocational/Employment	☐	Medical/Physical Health
☐	Income/Financial	☐	Social Skills/Natural Supports	☐	Transportation
☐	Education	☐	Other (Specify)		

List below a brief summary of the individual's current situation, a description of the individual's support system and available information on past interventions:

Referral Made by:		Phone Number:	
Encounter Type:	☐ Phone Call ☐ Walk-in ☐ Other:		
Follow Up Needed:	☐ Emergent (within 24 hrs) ☐ Urgent (within 48 hrs) ☐ Other (within 3 business days)		
Is the individual aware of this referral?		Referral Completed by:	
Follow Contact Completed by:		Date Completed:	