Pathways Integrated Health Services

Referral Form

Client Name (First Middle Last):	Gender: ☐ M ☐ F
Title 19 ID:	Date of Birth:

Currently Living With (if minor):		Relationship to Client:		
Main Phone/Contact Name:		Secondary Phone/Contact Name:		
Street Address:		City:	State:	Zip Code:
Legal Guardian (if different from above):		Relationship to Client:		
Main Phone/Contact Name:		Secondary Phone/Contact Name:		
Street Address:		City:	State:	Zip Code:
Referral Name/Agency:	Referral Phone:	Referral E-Mail:	Referral Fax:	
Primary Care Physician/Clinic:	PCP Phone:	Mental Health Therapist/Agency:	MHT Phone:	
Psychiatrist/Agency-Clinic:	Psychiatrist Phone:	Other Service Provider: (include pharmacy)	Other S.P. Phone	
Diagnosis:				

Pediatric only Is the child on the Child Mental Health Waiver	☐ Yes ☐ No	Provider and Phone Number:
Pediatric and Adult Are there emotional and/or behavioral issues that impact any area of the client's life?	☐ Yes ☐ No	Please check all areas that apply: Community ☐ Yes ☐ No School ☐ Yes ☐ No Work ☐ Yes ☐ No Home ☐ Yes ☐ No Other: ______________ ☐ Yes ☐ No
Pediatric and Adult Requesting Habilitation Services	☐ Yes ☐ No	Areas of Need: Please check all that apply Housing ☐ Yes ☐ No Transportation ☐ Yes ☐ No Daily Living Skills ☐ Yes ☐ No Employment ☐ Yes ☐ No Day Hab Programming ☐ Yes ☐ No 24 Hour Habilitation Home ☐ Yes ☐ No
If you are unsure of what the client may need please explain needs/barriers:		

Please send referral form to agency listed below.

Pathways **Behavioral Services** **Integrated Health Services**	Jennifer Riley: Jennifer.Riley@Pathwaysb.org Fax: 888-974-8571 or email to: Jennifer.Riley@pathwaysb.org Phone: 319-235-6571