INSPIRING MINDS THERAPEUTIC SERVICES - CLIENT REFERRAL FORM

10900 Northwest Freeway, Suite 129, Houston, TX 77092 | (832) 870-5858 | (832) 316-9849

www.imtsnow.com

Referral Date:	Referral ID:	Referring Staff:

CLIENT INFORMATION

Name:	DOB:	Phone:	Alt Phone:

Address: **City:** **ZIP:**

INSURANCE & ELIGIBILITY

☐ Medicaid ☐ Medicare ☐ Private ☐ Uninsured	**MCO:**	**Member ID:**

CLINICAL INFORMATION

Primary Diagnosis/Symptoms:

Current Medications:	Prescriber: Phone:

FUNCTIONAL IMPAIRMENT (Check all that apply)

☐ Daily living skills	☐ Symptom management
☐ Social relationships	☐ Community integration
☐ Employment/vocational	☐ Crisis management
☐ Medication management	☐ Other:

REQUESTED SERVICES & REFERRAL SOURCE

Services: ☐ PSR ☐ Skills Training ☐ Med Mgmt ☐ Case Mgmt	**Source:** ☐ Community ☐ Healthcare ☐ Family ☐ Self ☐ Other:

Referral Reason/Goals:

EXCLUSION SCREENING (Check if present)

☐ Active substance use requiring detox/residential ☐ Acute psychiatric symptoms requiring hospitalization
☐ Severe cognitive impairment ☐ History of violence toward staff
☐ Previous IMTS discharge for cause (past 12 months) ☐ **None of the above**

Emergency Contact: Phone:	Additional Notes:

Staff Signature:	Date:

FOR OFFICE USE ONLY: ☐ Clinical Verified ☐ Insurance Verified ☐ Geographic Verified ☐ No Exclusions

☐ Authorization Obtained **Date:**

☐ 30-Day Complete ☐ Bonus Qualified

Reviewed By:

Date: