

## REFERRAL & INTAKE FORM

REFERRAL					
Referral Date:	Name of Referral Source (List agency/company name):	Name of Person Making Referral:			
Phone Number for Person Making Referral:		Fax Number for Person Making Referral:			
CLIENT INFORMATION					
Client Name:		DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Medicaid #:		Language Preference:			
Parent/Guardian Name (if client is under 18):					
Residential Address:			City:	ZIP:	County:
Phone Numbers:	Home:	Work:	Cell:	Other:	
Health Condition/Health Risk (Child) or High-Risk Condition (Pregnant Woman) / Case Management Needs Per Referral Source:					
Referral section completed by:					
INTAKE (completed by case manager with client/parent/guardian)					
Date of Intake:		Information provided by:			
<input type="checkbox"/> Information same as provided by referral source					
<input type="checkbox"/> Additional information provided by client/parent/guardian; Include expected date of delivery if pregnant:					
Outcome of Referral:					
<input type="checkbox"/> Eligible needs. Submit initial prior authorization request for case management services.					
<input type="checkbox"/> Routine medical and dental needs. Refer to Texas Health Steps Hotline or MCO.					
<input type="checkbox"/> Routine medical transportation needs. Refer to Medical Transportation Program.					
<input type="checkbox"/> Basic needs only. Refer to 2-1-1 or other community resource.					
<input type="checkbox"/> Not interested in case management services and/or no needs identified.					
<input type="checkbox"/> Other					
Attempts to Contact Client/Parent/Guardian					
Date of Attempts:		Action:			
1.					
2.					
3.					
Intake completed by:					