UnityPoint Health
Allen Hospital

Outpatient Behavioral Health Program
1825 Logan Avenue
Waterloo, IA 50703
Phone: (319) 226-2170
Fax: (319) 226-2105

Outpatient Behavioral Health Program Referral Form

Please fax completed referral form and documentation to: (319) 226-2105

Date:_____ Psychiatrist/Provider:_____ Provider Phone:_____

Client Name (First, Middle Initial, Last):_____

Gender: ☐ Male ☐ Female Guardian (if applicable):_____

DOB:_____ SS#:_____

Physical Address:_____

Mailing Address:_____

Phone #: Home:_____ Cell:_____

Emergency Contact and Phone#:_____

Primary Insurance Co. Name:_____ Insurance Phone #:_____

Policy/ID #:_____ Subscriber Name:_____

Chief Complaint / Reason for Referral:_____
_____
_____

Any Substance Use: ☐ Yes ☐ No
If yes, please describe:_____

Most recent Psychiatric Hospitalization (date and facility):_____

Current DSM-5 Diagnosis: (Please include ICD-10 Codes if available)
_____
_____

Other agencies Involved: ☐ Yes ☐ No (If yes, please list agency name & type of services received)
_____
_____
_____

****Please attach supporting documentation including most recent psychiatric evaluation, progress notes, copy of insurance card and medication list. Referrals will not be reviewed without all information requested.**