UnityPoint Health
St. Luke's

UnityPoint Health® – St. Luke's Outpatient Behavioral Health Program
Referral Form

Date: _____ **Psychiatrist:** _____ **Provider Phone:** _____

Client Name (first, middle initial, last): _____

Gender: ☐ **Male** ☐ **Female** **DOB:** _____ **SSN:** _____

Physical Address: _____

Mailing Address: _____

Home Phone: _____ **Emergency Contact and Phone #:** _____

Guardian (if applicable): _____

Primary Insurance: _____ **Insurance Phone #:** _____

Policy/ID #: _____ **Subscriber Name:** _____

Chief complaint / Reason for referral: _____

_____

_____

Any Substance Use: ☐ **Yes** ☐ **No**

Describe: _____

Most Recent Psychiatric Hospitalization: _____

Current DSM V Diagnosis (include ICD-10 codes): _____

Current Psychiatric Medications: _____

_____

_____

Other Agencies Involved: ☐ **Yes** ☐ **No** (If yes, list agency & type of services received): _____

_____

_____

****Please attach supporting documentation including most recent psychiatric evaluation, progress notes, and medication list****

Return completed form to:

UnityPoint Health – St. Luke's Outpatient Behavioral Health Program
Phone: (712) 279-3974 Fax: (712) 234-8524