Phone (515) 612-9583
Fax (515) 393-2656
Email embrace@embracehealth.com

Referral Partner Initial Intake Form

Referral Request for Psychiatry/Therapy via Telehealth

Person Submitting Referral:_____

Org Name: _____

Contact's Name, Email, Phone: _____

Referral Notes:_____

Type and Care Requested:

○ 7 Day Follow Up ○ 0 Day Follow Up ○ Lacks Access to Care ○ Psychiatry (Med Management) ○ Therapy (Counselling) ○ Group Therapy (Counselling in Group Setting)

Video Capability:

○ Mobile Phone ○ Computer ○ Other

If Other, Please Describe:_____

Reason for visit:_____

Patient Information:

Member Name: _____

DOB (MM/DD/YYYY):_____

Street address, city, state, zip:

_____

_____

Email Address: _____

☐ Is this a mobile phone?

Phone(s): _____

Parent/Guardian Name (if applicable):_____

Insurance Coverage

Name ofCompany: _____

ID#:_____

Medicaid ID # (if applicable):_____

Responsible Party: _____

Reason for Admit: (inpatient)_____

Discharge Date (if applicable):_____

Medications/Allergies:_____

Preferred Pharmacy/ Phone#:_____

Preferred Language:_____

Additional Languages Spoken:_____

Ethnicity:_____

Gender:_____Preferred Pronouns:(please check applicable)

She/her/hers:_____He/him/his:_____They/them/theirs:_____Other**:_____**

Cultural, religious or spiritual preferences:_____