Please Fax Referral Form to: 866-371-4056

Mental Health Services Referral Form

Date of Referral: ____________

Referral Source

Referring Provider Name ____________________ Agency ______________ Contact Phone # _______________

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name ________________________________ Medical Record Number (if applicable) ______________

Address (incl. zip code) ____

Home Phone # _____________________ Cell Phone # _____________________ Social Security # _____________

DOB __/__/____ Sex _______ Race _______________ Marital Status Single Married Divorced Widowed

Insurance Type: Medical Assistance # _______________ Medicare Other ___________________________

Emergency Contact Name ___________________ Relationship to Patient ____________ Contact # ____________

Primary Care Physician ______________________ Clinic Name _____________________ Phone _____________

Current Type of Housing (e.g., group home): _______________________________________ Veteran Yes No

Potential Transportation Issues? No Yes Explain____

CLINICAL INFORMATION

Reason for Referral ____

____

Diagnosis (*list confirmed if known, if not list suspected*)

Primary Psychiatric Diagnosis ____

Secondary Psychiatric Diagnoses (including substance abuse) ____

Relevant Medical Diagnoses ____

Relevant Social Factors ____

Past Psychiatric History (hx) and Treatment (*please check appropriately*)

Former patient in clinic referred to? No Yes, details ____

Hx of violence? No Yes, details ____

Hx of suicide attempts? No Yes, details ____

Hx of psychiatric hospitalizations? No Yes, details ____

Previous symptoms and diagnoses ____

Current Psychiatric Treatment & History

Current Symptoms ____

Current suicidal / homicidal thoughts? No, Yes, details ____

Does patient have a current outpatient mental health provider? No Yes, details _______________________

Reason not returning ____

Additional Information ____

____

Current Psychiatric Medications (*name & dose*, attach list if preferred)

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Signature of Referral Source ____ Date / Time __________________