

Rooted Counseling & Consulting Group, LLC Referral Form

Date of Referral: _____

Services Seeking: Group Therapy Adult Individual/Family Therapy LGBTQA+ Life Coaching
Marital/Couple Therapy Providers Group Therapy CBT/DBT Teenager men/women Group Therapy

Referral Source

Referring Provider Name _____ Agency _____ Contact Phone # _____

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name _____ Email: _____

Address (incl. zip code) _____

Home Phone # _____ Cell Phone # _____ 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 the 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)

Signature of Referral Source _____ Date / Time _____