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)
_____
_____
_____

Signature of Referral Source _____ Date / Time _____