INTEGRITY COUNSELING

Mental Health Services Referral Form – linaintegritycc@gmail.com (Scan or e-mail)

Referring Provider Name/Agency ____________________________________ Date _______________________

Phone Number _____________________________________ E-mail _____________________________________

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name ____ DOB _______________________________

Home Number __________________________________ Cell Number __________________________________

Address _______________________________________ City ___________________ State _________________

Zip Code _______________ Race ____________________ Sex __________ Email: _________________________

Marital Status Single Married Divorced Widowed

Emergency Contact Name ______________________________ Relationship to Client ______________________

Phone Contact Number ____________________________

INSURANCE INROMATION

Insurance Type: Medicaid FFS ____ Silver Summit ____ Anthem Blue Cross ____ Cash Pay _____

Insurance ID Number _________________________________

CLINICAL INFORMATION

Referral Reason ____

Services Requested: _____ Therapy _____ Assessment _____ PSR _____ BST _____ Life Coaching

Psychiatric Diagnosis (Including Substance abuse) ____

Relevant Medical Diagnosis/Social Factors:

____

PAST PSYCHIATRIC HISTORY AND TREATMENT

History of Violence? No Yes, Details ____

History of Suicide Attempts? No Yes, Details ____

History of Psychiatric Hospitalization No Yes, Details ____

CURRENT PSYCHIATRIC TREATMENT AND HISTORY

Current Symptoms ____

Current Suicidal/ Homicidal thoughts? No Yes, Details ____

Does client have a current outpatient mental health provider? No Yes, Details ____________________________

Current Psychiatric Medications (name and dose, attach list if preferred)____________________________________