MIDTOWN PSYCHIATRY
REFERRAL FORM

1222 NE 4th Street | Bend, Oregon
Phone: 541-640-5460 | Fax: 541-648-5771

For healthcare professionals referring patients for psychiatric evaluation and/or medication management.

Submission does not guarantee acceptance. This form is not monitored for urgent or crisis needs; call 988 or 911 when appropriate.

1. PATIENT INFORMATION

PATIENT NAME

DATE OF BIRTH

PRONOUNS (OPTIONAL)

PHONE

EMAIL

INSURANCE

2. REFERRING PROVIDER

NAME AND CREDENTIALS

PRACTICE / AGENCY

PHONE

FAX

SECURE EMAIL

3. REASON FOR REFERRAL (CHECK ALL THAT APPLY)

- ☐ Psychiatric evaluation
- ☐ Medication evaluation / management
- ☐ Diagnostic clarification
- ☐ Depression
- ☐ Anxiety / panic
- ☐ ADHD / attention concerns
- ☐ Mood instability / bipolar concerns
- ☐ Trauma-related symptoms
- ☐ Sleep concerns
- ☐ Medication side effects
- ☐ Inadequate treatment response
- ☐ Other

OTHER / ADDITIONAL REASON

4. CLINICAL INFORMATION

CURRENT SYMPTOMS, FUNCTIONAL IMPAIRMENT, AND WHY PSYCHIATRIC CARE IS REQUESTED NOW

KNOWN OR SUSPECTED DIAGNOSES

THERAPY DURATION / FREQUENCY

CURRENT PSYCHIATRIC MEDICATIONS; PRIOR TRIALS OR SIGNIFICANT ADVERSE REACTIONS (IF KNOWN)

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5. SAFETY / URGENCY

- ☐ No current safety concern known
- ☐ Current/recent suicidal ideation or self-harm
- ☐ Recent psychiatric hospitalization
- ☐ Substance-use concern
- ☐ Aggression / violence risk
- ☐ Other significant safety concern

BRIEF DETAILS, INCLUDING RELEVANT DATES AND CURRENT SAFETY PLAN

6. REQUESTED SERVICE AND RECORDS

- ☐ Consultation only
- ☐ Ongoing medication management
- ☐ Diagnostic consultation
- ☐ Therapy summary
- ☐ Medication list
- ☐ Testing / evaluation
- ☐ Other records attached

WHAT WOULD YOU LIKE THE PSYCHIATRIC PROVIDER TO ASSIST WITH?

7. CARE COORDINATION

- ☐ Patient has authorized communication between providers
- ☐ ROI pending / will be sent

PRIMARY CARE PROVIDER (IF KNOWN)

REFERRAL DATE

REFERRING PROVIDER SIGNATURE / TYPED NAME