CLAYTOR MEMORIAL CLINIC

# Outpatient Referral Form

1127 2nd Street, SW, Roanoke, VA 24016
Phone: 540-400-7495 Fax: 877-803-9136

10401 Warwick Blvd., Newport News, VA 23601
Phone: 757-782-2643 Fax: 877-803-9136

admin@claytorclinic.com
www.claytormemorialclinic.com

| DATE OF REFERRAL: | |
|---|---|

| SERVICE DESIRED: | | Psychiatric Services |
|---|---|---|

| Chief Complaint/ Presenting Problem: | |
|---|---|
| | |

| PATIENT DEMOGRAPHIC, INSURANCE, AND DIAGNOSTIC INFORMATION | | | |
|---|---|---|---|
| Name: | | | |
| Address: | | | |
| Home Phone: | | Date of Birth: | |
| Cell Phone: | | Gender at birth: | |
| Work Phone: | | Race: | |
| Social Security Number: | | Marital Status: | |
| | | | |

| INSURANCE INFORMATION: | |
|---|---|
| Medicaid MCO & ID Number: | |
| Private Insurance Name and Phone Number | |
| Private Insurance Behavioral Health Name and Phone Number | |
| Private Insurance ID and Group Number | |
| Private Insurance Policy Holders Name and SSN | |

| DIAGNOSTIC INFORMATION: | |
|---|---|
| Axis I: | |
| Axis II: | |
| Axis III: | |
| Axis IV: | |
| Axis V: | |
| | |

| LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE/POA INFORMATION (If Applicable) | | | | | |
|---|---|---|---|---|---|
| Name: | | | | Relationship: | |
| Address: | | | | | |
| Home Phone: | | Cell Phone: | | Work Phone: | |

| EMERGENCY CONTACT INFORMATION | | | | | |
|---|---|---|---|---|---|
| Name: | | | | Relationship: | |
| Address | | | | | |
| Home Phone: | | Cell Phone: | | Work Phone: | |

| CURRENT SERVICE PROVIDERS: | | |
|---|---|---|
| | MHSS PROVIDER: | |
| | PSYCHIATRIST: | |
| | OUTPATIENT COUNSELOR: | |
| | OTHERS: | |

| REFERRING PARTY NAME: | | REFERRING AGENCY: | |
|---|---|---|---|
| MAILING ADDRESS: | | | |
| TELEPHONE NUMBER: | | E-MAIL ADDRESS: | |
| FAX NUMBER: | | | |

**Please fax referral form to Claytor Memorial Clinic at 877-803-9136**