



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 Company: _____ Insurance ID#: _____

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 _____