REFERRAL FORM- ADULT

BRAIN GARDEN PSYCHIATRY
Fax to: (916) 581-8669 (Secure & HIPAA-Compliant)
Questions? Email: info@braingardenpsychiatry.com
www.braingardenpsychiatry.com
(916) 299-7244

Patient Information

- Name: _____
- Date of Birth: _____ Age: _____
- Phone Number:_____
  _____
- Email Address: _____
- Address: _____
- _____

Referring Provider

- Name: _____
- Credentials: _____
- Practice Name: _____
- Phone: _____ Fax: _____
- Email: _____

Reason for Referral *(Check all that apply)*

☐ Depression / Major Depressive Disorder
☐ Generalized Anxiety Disorder / Panic Disorder
☐ Social Anxiety Disorder / Agoraphobia
☐ Bipolar I / Bipolar II / Cyclothymia
☐ Mood Disorder NOS
☐ ADHD / Executive Dysfunction (new or ongoing)
☐ ADHD Evaluation
☐ Autism Evaluation
☐ Autism Spectrum Disorder / Neurodivergence
☐ PTSD / Acute Trauma
☐ Complex PTSD (CPTSD)
☐ Adjustment Disorder
☐ OCD / Intrusive Thoughts / Compulsions
☐ Schizophrenia or other psychotic disorder
☐ Eating Disorder / Disordered Eating
☐ Postpartum Depression / Perinatal Mood Disorders
☐ Grief / Loss / Existential distress
☐ Functional Psychiatry / Integrative Assessment

☐ Medication Management
☐ Other: _____

Current Psychiatric or Medical Providers

- Psychiatrist / PCP: _____
- Therapist:
  _____
- Other: _____

Additional Notes or Concerns (Optional):

_____

_____

_____

Please fax this completed form to (916) 581-8669. We will follow up directly with the patient for scheduling. Thank you for your referral and partnership.

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