PSYCHIATRIC PRE-OP REFERRAL FORM

Brain Garden Psychiatry

Carrie Friedman, MSN, FNP-BC, PMHNP-BC

Psychiatric Pre-Operative Evaluation Referral Form

Fax: 916-581-8669
info@braingardenpsychiatry.com
916-299-7244
www.braingardenpsychiatry.com

Referring Provider Information

- Referring Surgeon Name: _____
- Practice Name: _____
- Phone Number: _____
- Fax Number: _____
- Email (optional): _____

Patient Information

- Full Name: _____
- Date of Birth: _____
- Phone Number: _____
- Email: _____
- Preferred Language: _____
- Is the patient aware of and consenting to this referral? (Yes / No): _____

Surgical Information

- Type of Surgery Planned: _____
- Planned Surgery Date: _____
- Surgical Facility Name: _____
- Is this an elective procedure? (Yes / No): _____
- Significant Medical History (including relevant diagnoses or conditions):

_____

_____

- Current Medications (including psychiatric and medical):

  _____
  _____

- Relevant Psychiatric History (e.g., diagnosis, prior hospitalizations, concerns):

  _____
  _____

Request Details

- Reason for Psychiatric Clearance Request (check all that apply):
  ☐ Standard pre-op psychiatric assessment
  ☐ History of psychiatric diagnosis or treatment
  ☐ Concern about capacity or decision-making
  ☐ Other (please specify): _____

Additional Notes:

_____
_____
_____

Referral Submission
Submit this completed form via:
Fax: 916-581-8669
Email (secure): info@braingardenpsychiatry.com
Phone: 916-299-7244 for questions or urgent needs