REFERRAL FORM

BRAIN GARDEN PSYCHIATRY
Fax to: (916) 581-8669 (Secure & HIPAA-Compliant)

Questions? Email: info@braingardenpsychiatry.com
www.braingardenpsychiatry.com Office: (916) 299-7244

Patient Information

- Name: _____
- Date of Birth: _____Age: _____
- Parent/Guardian Name (if minor): _____
- Phone Number: _____
- Email Address: _____
- Address: _____
- _____

Referring Provider

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

Reason for Referral (check all that apply)

☐ Autism Spectrum Disorder – diagnostic support or co-occurring symptoms
☐ ADHD / Executive Function Issues – inattentiveness, focus, or planning deficits
☐ Anxiety / Panic – chronic worry, phobias, or acute distress episodes
☐ Emotional Dysregulation / Mood Swings – irritability, anger, shutdowns, or lability
☐ Sensory Processing Difficulties – hypersensitivity or avoidance behaviors
☐ Sleep / Fatigue / Shutdowns – insomnia, sleep phase delay, or burnout
☐ OCD or Repetitive Behaviors – compulsions, rituals, or intrusive thoughts
☐ Trauma History – early adversity, medical trauma, or complex PTSD features
☐ Diagnostic Clarification – Autism vs ADHD vs. AuDHD, comorbidities, masking
☐ Functional Psychiatry Evaluation – root cause investigation and functional testing
☐ Nutritional / GI / Metabolic Support – feeding challenges, gut health, or nutrient status
☐ Other: _____

Current Psychiatric or Medical Providers

- Psychiatrist/Pediatrician: _____
- Therapist: _____
- Other: _____

Additional Notes or Concerns (Optional):

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