CLAYTOR MEMORIAL CLINIC

Outpatient Referral Form

124 Wells Ave. NW, Roanoke, VA 24016
Phone: 540-516-5116 Fax: 877-702-6432

10401 Warwick Blvd., Newport News, VA 23601
Phone: 757-782-2643 Fax: 877-702-6432

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 877-702-6432