MEDICATION EVALUATION
REFERRAL FORM

REFERRAL SOURCE	
Agency:	Agency Location:
Form Completed By:	Your Contact Phone Number:
CLIENT INFO	
Name:	DOB:
Address:	Phone number:
Parent/Guardian name (If applicable):	Parent/Guardian Phone #:
Health ins company:	Insurance ID:
Current Diagnoses with ICD-10 CODES:	PCP (Primary Care Physician):
Please list any safety concerns:	Current psychotropic medications:

APPROPRIATE REFERRAL	REFER OUT
• ADHD • Anxiety • Depression • Insomnia • PTSD • SSRI, SNRIs, atypical, and non-controlled sleep aids	• Bipolar Disorder • Schizophrenia • Personality Disorders • Substance Use Disorder medications • Ages 12 and younger • Benzodiazepines or narcotics

Please send the most recent diagnostic assessment and a signed ROI.

PLEASE FAX COMPLETED FORM TO: 763-244-1243

REFERRAL DOES NOT GUARANTEE A CURRENT OPENING. WE WILL DO OUR BEST TO GET NEW CLIENTS IN.