Ubuntu Psychotherapy group **Services Referral Form**

UBUNTU PSYCHOTHERAPY GROUP, LLC
Discovering new version of ourselves

Date of Referral: _____

Services Seeking: ☐Group Therapy ☐Adult Individual/Family Therapy ☐SOAP/ Substance Use IOP ☐ Marital/Couple Therapy ☐Providers Group Therapy ☐CBT/DBT ☐Teenager men/women Group Therapy

Referral Source
Referring Provider Name _____ Agency _____ Contact Phone # _____

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name _____ Medical Record Number (if applicable) _____
Address (incl. zip code) _____
Home Phone # _____ Cell Phone #_____ Social Security # _____DOB ___/__/____
Sex_____ Race _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow
Insurance Type: ☐ Medical Assistance # _____ ☐ Medicare #_____ ☐ Other
Name/#_____Emergency Contact Name _____Relationship to Patient
_____ Contact # _____ Primary Care Physician _____
Clinic Name _____ Phone _____ Current Type of Housing (e.g., group home):_____ Veteran ☐Yes ☐NO Potential Transportation Issues? ☐No ☐Yes Explain_
_____

CLINICAL INFORMATION

Reason for Referral _____
_____

Diagnosis (*list confirmed if known, if not, list suspected*)
Primary Psychiatric Diagnosis _____
Secondary Psychiatric Diagnoses (including substance abuse) _____
Relevant Medical Diagnoses _____
Relevant Social Factors _____

Past Psychiatric History (hx) and Treatment (*please check appropriately*)
Former patient in clinic referred to? ☐ No ☐ Yes, details _____
Hx of violence? ☐ No ☐ Yes, details _____
Hx of suicide attempts? ☐ No ☐ Yes, details _____
Hx of psychiatric hospitalizations? ☐ No ☐ Yes, details _____
Previous symptoms and diagnoses. _____

Current Psychiatric Treatment & History
Current Symptoms _____
Current suicidal/homicidal thoughts? ☐ No, ☐ Yes, details _____
Does the patient have a current outpatient mental health provider? ☐ No ☐ Yes, details _____
Reason not returning _____
Additional Information. _____
_____

Current Psychiatric Medications (*name & dose*, attach list if preferred)
_____
_____

Signature of Referral Source _____ Date / Time _____