PSYCHIATRY REFERRAL FORM

Mental Wellness for the Human Experience, LLC

> Most referrals are reviewed within 1 business day. Appointments typically available within 48–72 hours.

REFERRING PROVIDER INFORMATION

(Required unless noted)

Referring Provider Name *

Practice / Organization *

Provider Type *

☐ PCP ☐ Therapist ☐ Psychiatrist ☐ NP/PA ☐ Other

Phone Number *

Fax Number *

Secure Email *

Preferred method of contact

☐ Phone ☐ Email ☐ Fax

Would you like feedback after evaluation?

☐ Yes ☐ No

PATIENT INFORMATION

Patient Full Name *

Date of Birth *

Patient Phone Number *

Patient Email *

Preferred Language *

Is the patient aware of and agreeable to this referral? *

☐ Yes ☐ No

REFERRAL TYPE

Reason for Referral *

☐ Psychiatric diagnostic evaluation

☐ Medication initiation

☐ Medication optimization

☐ Second opinion

☐ Transfer of psychiatric care

Primary Clinical Focus *

☐ Major Depressive Disorder

☐ Anxiety Disorders

☐ Mood Disorders (Bipolar spectrum)

☐ ADHD

☐ PTSD

☐ Other

CLINICAL SUMMARY

Brief clinical summary / reason for referral *

Current psychiatric medications (if any)

Relevant medical conditions (Optional)

SAFETY SCREEN (REQUIRED)

Current suicidal ideation? *

☐ No ☐ Yes

History of suicide attempts?

☐ No ☐ Yes

Current psychosis or mania?

☐ No ☐ Yes

If YES to any above, please briefly explain:

“This clinic is not an emergency service. If the patient is in immediate danger, please direct them to emergency services.”

INSURANCE

Primary Insurance

☐ Anthem ☐ Aetna ☐ Cigna ☐ United ☐ Medicaid ☐ Medicare ☐ Self-pay ☐ Other

Is the patient open to self-pay if needed?

☐ Yes ☐ No ☐ Unknown

Referrer Attestation Checkbox *

☐ “I confirm this referral is accurate and the patient has consented to referral.”