Mental Health Services Referral Form

Date of Referral: _____

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 □ Widowed
Insurance Type: □ Medical Assistance # _____ □ Medicare □ Other _____
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 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 _____