FAX: 888-789-8394 or EMAIL: btownoffice2@newoutlookcc.org

Psychiatric Referral Form

Referring Provider Name:___________________________________ Agency: ______________________

Referral Phone # and Email: ____

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name ____

Address (incl zip): ____

Home Phone#:______________________ Cell Phone#: _____________________ SSN: __________________

DOB: ___/___/___ Sex: ____ Race: _______________ Marital Status: Single Married Divorced Widowed

Insurance Type: __________________ Insurance ID#:____________________________ Group ___________

Emergency Contact Name: _________________ Relationship to Patient:___________ Contact #:__________

Primary Care Physician: ______________________________ Phone #: _______________________________

CLINICIAL 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 and Treatement (*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 ____

Hx of Residential Treatment? No Yes Details ____

Previous symptoms and diagnoses: ____

Family hx of chronic mental health diagnosis? ____

Current Psychiatric Treatment and History

Current Symptoms: ____

Current suicidal/homicidal thoughts? No Yes Details____

Does patient have current outpatient mental health provider? No Yes Details ___________________________

Additional Information: ____

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

____

Signature of Referral Source: ___________________________________ Date/Time____________________