New Outlook Counseling Center Inc.

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 _____

Previous symptoms and diagnoses: _____

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_____