Fax: 1-888-78-8394 or Email: newoutlookoffice3@gmail.com

Psychiatric Referral Form

Referring Provider Name ________________________________ Agency ________________

Referral Phone # and Email ____

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name ____

Address (incl zip code)____

Home Phone # ____________________ Cell Phone # ____________________ Social Security # ____________

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 # _________________________

CLINICAL INFORMATION

Reason for Referral ____

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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 ______________________

Additional Information ____

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

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Signature of Referral Source ______________________________________ Date / Time _________________