PROVIDER REFERRAL FOR PSYCHIATRIC CARE

Please complete and fax to: 844-908-2213

Referring Provider's Name: ____
Referring Provider's Phone: ____
Referring Provider's Fax: ____

Client Name: ________________________ Date of Birth:______________________________
Client Phone Number: _________________ Insurance Company: _______________________
Primary Care Provider:_________________ Therapist: ________________________________

Please describe the current clinical details regarding this patient:

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How would seeing a psychiatrist benefit this patient?

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Does this patient have a history of substance **abuse** that you are aware of? If so, please specify.

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Has this patient been diagnosed with, or do you suspect, a personality disorder? Please specify.

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Is the patient currently taking psychiatric medications? If known, please list:

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Has the patient been hospitalized psychiatrically? If so, when?

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Has the patient had suicide attempts? If so, when?

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