Psychiatric Referral Form

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Thank you for considering a referral of your patient to my practice. I hope this form will make it easier for me to understand your needs and your patient's needs. Please FAX (or mail) this form to me at the above address. This referral form will be shredded when no longer needed.

Your Name: _____ Date: _____

Your Contact Details: _____

Do you need to be contacted before I call your patient? _____

How would you like me to brief you on my evaluation? _____

Patient Name: _____ DOB: _____ Gender: _____

If not adult: Parent(s)/Guardian Names: _____

Contact Telephone Numbers and Email Address:

_____ _ _____

Referral reason or question:

_____ __ _____

Why now?

_____

Safety issues, alcohol or drug use, psychosis, medical problems, recent hospitalizations?

_____

What has worked/not worked for your patient, if past psychiatric care?

_____

What are your patient's strengths? Personal, support systems, etc.

_____

Patient's Insurance:_____