Referring Provider Name Agency Contact Phone #

# PATIENT DEMOGRAPHIC INFORMATION

Patient’s Name Address (incl. zip code) Home Phone # Cell Phone # Social Security # DOB / / Sex at birth Gender Identity Race Marital Status  Single  Married  Divorced  Widowed Insurance Carrier Id Number: Patients Email Address Emergency Contact Relationship to Patient Contact Phone#

Primary Care Physician Phone Fax: Current Type of Housing (e.g., group home): Does Patient have a legal Guardian?  No  Yes Name of Guardian

Is patient a Veteran  Yes  No

# CLINICAL 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 (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 *Reason not returning*  Additional Information

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

**Signature of Referral Source**  Date / Time