Referral Form

Date of Referral: _____

Please email to Jmullis@precisepsych.com or Fax to 888-493-0179

Referral Source

Referring Provider Name _____ Agency ___

Contact Phone #[redacted]

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name _____ Email Address: _____

Address (incl. zip code) _____

Home Phone # _____ Cell Phone # _____ _____

DOB __/__/_____ Sex _____ Race _____ Marital Statu☐ Singl☐ Marrie☐ Divorce☐ Widowed

Insurance Type:_____

Primary Care Physician _____ Clinic Name _____ Phone _____

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? Δ No Δ Yes, details _____

Hx of suicide attempts? Δ No Δ Yes, details _____

Hx of psychiatric hospitalizations? Δ No Δ Yes, details _____

Previous symptoms and diagnoses _____

Current Psychiatric Treatment & History

Current Symptoms _____

Current suicidal / homicidal thoughts? Δ No, Δ Yes, details _____

Does patient have a current outpatient mental health provider? Δ No Δ Yes, details _____

Will they be returning? Δ No Δ Yes, details_____

Additional Information _____

_____

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

_____

_____

_____

Signature of Referral Source _____ Date / Time _____