Referral Form

Referral Source Information

Referring Provider: ______________________________ Agency Name: _______________________

Agency Contact: _____________________________ Contact Number: ________________________

Client Information

Client Name: ______________________________________ Date of Birth: ______________________

Guardian Name (if applicable): ______________________________ Relationship: ______________

Phone Number: ___________________ Alternate Number/Email: _____________________________

Insurance Type: ___________________________ Insurance ID Number: ______________________

Reason for Referral: ____

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Diagnosis (list confirmed or suspected):

Primary Mental Health Diagnosis: ____

Secondary Mental Health Diagnosis: ____

Relevant Medical Health Diagnosis: ____

Relevant Social Factors: ____

Current Mental Health:

Current Symptoms: ____

Current suicidal/homicidal thoughts: ☐ no ☐ yes _______________________________________

List other mental health providers client is seeing: _______________________________________

List Current Medications: ____

Additional Information: ____

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Referral Source Signature

____ ___________________________

Signature of Referral Source *Date*

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