

# JL Counseling

## Mental Health Services Referral Form

Date of Referral: \_\_\_\_\_

### Referral Source

Referring Provider Name \_\_\_\_\_ Agency \_\_\_\_\_ Contact Phone # \_\_\_\_\_

### PATIENT DEMOGRAPHIC INFORMATION

Patient's Name \_\_\_\_\_ Medical Record Number (if applicable) \_\_\_\_\_

Address (incl. zip code) \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Social Security # \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ Marital Status  Single  Married  Divorced  Widowed

Insurance Type:  Medical Assistance # \_\_\_\_\_  Medicare  Other \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Contact # \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Clinic Name \_\_\_\_\_ Phone \_\_\_\_\_

Current Type of Housing (e.g., group home): \_\_\_\_\_ Veteran  Yes  No

Potential Transportation Issues?  No  Yes Explain \_\_\_\_\_

### 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 \_\_\_\_\_