



Return via FAX: 888-789-8394 or EMAIL: btownoffice2@newoutlookcc.org

Psychiatric Medication Management Referral Form

Referring Provider Name: _____ Agency: _____

Referral Phone # and Email: _____

PATIENT DEMOGRAPHIC INFORMATION

*Patient's Name _____

Address (incl zip): _____

*Main Phone#: _____ (name of contact if a guardian) Alt Phone#: _____

*Email: _____ Marital Status: Single Married Divorced Widowed

SSN: _____ *DOB: ____/____/____ *Sex: _____ Race: _____

*Insurance Type: _____ Insurance ID#: _____

*Insurance Subscriber Name and DOB _____

Emergency Contact Name: _____ Relationship: _____ Contact #: _____

Primary Care Physician/Current Prescriber: _____ Phone #: _____

Therapist (if applicable): _____ Contact Info: _____

****Please have patient sign a Release of Information for current/past psych medication provider and/or therapist if applicable, and send with completed referral form.**

**** Release of Information forms and Referral forms can be found on www.newoutlookcc.com under the "forms" tab.****

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 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 _____

Hx of Psychosis or Delusions? No Yes Details _____

Previous symptoms and diagnoses: _____

Current Psychiatric Treatment and History

Current Symptoms: _____

Current suicidal/homicidal thoughts? No Yes Details _____

Does patient have current outpatient mental health provider? No Yes Details _____

Additional Information: _____

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

Signature of Referral Source: _____ Date/Time _____