



New Outlook Counseling Center

External Referral Form

Referring Provider's Name: _____ **Phone:** (812) 340-5447

Mailing Address: 5010 N. Stone Mill Rd. Suite B, Bloomington In 47408 **FAX:** (888) 789-8394

Provider's Office Location: **Madison Street** or **Stone Mill Rd**

Referral to: _____

-----**PATIENT DEMOGRAPHIC INFORMATION**-----

*Patient's Name: _____ *DOB: _____ Sex: _____

*Email Address: _____ Phone#: _____ AltPhone#: _____

Address (incl zip): _____

SSN: _____ *Insurance Type/Name: _____ *Insurance ID#: _____

Insurance Carrier's Name: _____ DOB: _____ Relationship: _____

Emergency Contact: _____ Relationship _____ Contact #: _____

-----**CURRENT CLINICAL/MEDICAL INFORMATION**-----

Primary Care Physician: _____ Phone #: _____

Current or Past Therapist: _____ Contact Info: _____

Reason for Referral: _____

Diagnosed ICD-10 Codes (Please insert Dx Code)

<input type="radio"/> Depressive Disorder _____	<input type="radio"/> Failure to thrive, child _____	<input type="radio"/> Mood Disorder _____
<input type="radio"/> Anxiety Disorder _____	<input type="radio"/> Anorexia Nervosa _____	<input type="radio"/> Borderline Disorder _____
<input type="radio"/> SUD _____	<input type="radio"/> Bulimia Nervosa _____	<input type="radio"/> Trauma _____
<input type="radio"/> ADHD _____	<input type="radio"/> Mixed Obsessional Thoughts _____	<input type="radio"/> Bipolar Disorder _____
<input type="radio"/> PTSD _____	<input type="radio"/> and Acts _____	<input type="radio"/> Manic Episodes _____
<input type="radio"/> Intellectual Disabilities _____	<input type="radio"/> Panic Disorder _____	<input type="radio"/> OCD _____
<input type="radio"/> Autistic Disorder _____	<input type="radio"/> Adjustment Disorder _____	<input type="radio"/> RAD _____
<input type="radio"/> Other _____	<input type="radio"/> Other _____	<input type="radio"/> Other _____

Current Medications (Please include dose and frequency. Attach list if needed) - _____

Additional Info/Notes: _____

Signature of Referral Source/Representative: _____ **Date:** _____

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