

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

Registered Dietitian Referral Form

Referring Provider Name: Agency:

Referral Phone # and Email:

**PATIENT DEMOGRAPHIC INFORMATION**

Patient’s Name Address (incl zip): Home Phone#: Cell Phone#: SSN:

DOB: / / Sex: Race: Marital Status: Single Married Divorced Widowed

Insurance Type: Insurance ID#: Group

Emergency Contact Name: Relationship to Patient: Contact #: Primary Care Physician: Phone #: **CLINICIAL INFORMATION**

Reason for Referral

Diagnosis *(list confirmed if known, if not list suspected)*

Primary Psychiatric Diagnosis: Secondary Psychiatric Diagnoses (including substance abuse): Any health conditions/diagnosis such as diabetes, hypertension, high cholesterol, etc \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ Any concerning behaviors, trauma, family issues around food and/or exercise\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relevant Social Factors: Past Psychiatric History and Treatment (*please check appropriately)*

Former Therapy? No Yes Details Hx of Psychiatric Hospitalizations? No Yes Details Hx of Residential Treatment? No Yes Details Previous symptoms and diagnoses: Family hx of chronic mental health/medical diagnosis?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Psychiatric Treatment and History

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