Comprehensive Psychiatric Care, PLLC
Referral Form
Phone: 423.708.8670
Fax: 423.708.8671

Referring Provider: _____ **Phone:** _____

PLEASE PRINT CLEARLY – Incomplete/illegible forms will not be processed. **Date of Referral:**

PATIENT INFORMATION:
Name: Last _____ First_____ **DOB:** _____

Address: _____

Patient seen Psychiatrist/Therapist? __ No __ Yes **Who:** _____

Insurance: _____ **Policy Holder:** _____ **DOB:** _____

Phone: _____ **Gender:** M F O **Is patient aware of this referral?** Y N

PRESENTING PROBLEMS:
(symptoms, duration, severity and contributing factors)

REFERRAL REASON:
(diagnostic clarification, consultation, treatment or recommendations)

CLINICAL FEATURES:

Suicidality: Ideation: __ No __ Active __ Passive Plan: __ No __ Yes _____ Attempts: __ No __ One __ More than one Date of last attempt: _____ Lethality of attempts: __ Low __ Moderate __ High	**SELF HARM BEHAVIOUR:** Current? __ No __ Yes Past? __ No __ Yes **AGGRESSIVE BEHAVIOUR:** Toward others? __ No __ Yes Toward property? __ No __ Yes
Previous Psychiatric Involvement(attach documentation): Presenting Problem Dates Hospitalized? _____ _____	**Substance Use** (alcohol & drug): ___ Current ___ Past Use Type Quantity Frequency _____ _____

****Please attach Progress Note, Medications, Labs, Demographics, & Copy of Insurance Card****