Patient Referral Form

Referring Provider Name_____ Contact Phone # _____

CLIENT INFORMATION

Name_____ Date of Birth_____

Address_____ City_____

State_____ Zip Code_____

Client Phone Number:_____

Guardian Name (if minor)_____ Relationship_____

Insurance:_____ ID #_____ Group#_____

Name of Insurer (if not self)_____ Relationship_____ Date of Birth_____

CLINICAL INFORMATION

Reason for Referral:

- Medication Management:_____
- Individual Therapy:_____
- Group Therapy:_____
- Targeted Case Management:_____

DIAGNOSES

(List confirmed if known, if not list suspected)

Primary Psychiatric Diagnosis (including substance abuse): _____

Relevant Medical Diagnoses: _____

Current Psychiatric Medications (list medication name, strength and dosage):_____

_____

****Please fax or email: Client's last office note, any lab work and neuropsych evaluation****

Signature of Referral Source_____ Date_____

Please email completed form to HaveHopePLLC@gmail.com or fax (502) 290-4073 and our office will contact client to schedule appointment.