MENTAL HEALTH REFERRAL FORM

Referring Provider Name: _____

Provider Contact Information (Phone/Email): _____

Patient Name: _____

Date of Birth: _____

Patient Contact Information (Phone/Email): _____

Reason for Referral:

Please describe the specific mental health concerns, symptoms, or behaviors that are prompting this referral. Include relevant history, duration, severity, and any immediate risks or safety concerns.

Current Medications:

_____

Relevant Medical/Psychiatric History:

Include any previous diagnoses, hospitalizations, therapy or counseling history, substance use, and any other relevant medical information.

Mental Status / Observations:

Briefly note current mental status, appearance, behavior, mood, thought processes, and any observations that may assist the mental health provider.

Risk Assessment:

Assess the presence of any suicidal ideation, homicidal ideation, self-harm, or other risks requiring immediate attention. Specify level of risk and any safety plans.

Requested Services:

Specify the type of mental health services requested (e.g., evaluation, therapy, medication management, crisis intervention).

Insurance Information (if applicable):

_____

Authorization:

I hereby authorize the release of relevant medical and mental health records to the receiving provider for continuity of care purposes. I confirm the accuracy of the above information to the best of my knowledge.

Referring Provider Signature: _____

Date: _____

Receiving Provider Name: _____

Receiving Provider Contact Information: _____

Receiving Provider Signature: _____

Date: _____

Referring Provider Signature

Signature: _____

Receiving Provider Signature

Signature: _____