Washington State Department of Social & Health Services

Transforming lives

Psychiatric Referral Summary

PRINT CLIENT NAME	DATE OF BIRTH	AGE	GENDER ☐ Male ☐ Female
ADDRESS CITY STATE ZIP CODE			
SUPPORTING AGENCY			
CONTACT PERSON			TELEPHONE NUMBER
LEGAL REPRESENTATIVE			TELEPHONE NUMBER
PRIMARY PHYSICIAN			TELEPHONE NUMBER
OTHER PHYSICIAN			TELEPHONE NUMBER
DDD CASE MANAGER			TELEPHONE NUMBER
PRINT NAME OF PERSON COMPLETING FORM			DATE
RELATIONSHIP TO CLIENT			

Briefly describe why this person is being referred for a psychiatric evaluation:

Symptom(s) or behavior(s) of concern (define and state frequency and severity of each symptom or behavior):

Previous mental health involvement (list past counseling, behavioral interventions, diagnoses, medications, psychiatric hospitalizations, crisis team contact, etc.):

List other agency contacts and telephone numbers (employment, vocational, mental health, other therapists, etc.):

What has been tried previously (list intervention and results, if known):

LIST DIAGNOSES/MEDICAL CONCERNS	CURRENT MEDICATIONS, DOSAGE AND FREQUENCY

List any known unusual or adverse reactions to medications:

Describe the following characteristics of the person (if not already listed)

SLEEP PATTERN

MOOD/AFFECT

EATING/APPETITE

THINKING/COGNITION

MEMORY

ANXIETY LEVEL

HYPERACTIVITY

SENSORY IMPAIRMENTS
ALLERGIES
GYNECOLOGICAL PROBLEMS
URINARY PROBLEMS
COMMUNICATION IMPAIRMENT
Other information that may be pertinent: