|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **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: |

|  |
| --- |
|  |