WE CARE BEHAVIORAL HEALTH REFERRAL FORM

Full Name (Last Name, First Name, Middle Name)

_____

DOB

_____

SSS

_____

Address (Street Address, City, State, Zip Code)

_____

Primary Telephone Number

_____

Mobile Telephone Number

_____

Email

_____

REFERRAL:

- ☐ PCP/PCP
- ☐ DCF/DYS
- ☐ Court/Legal
- ☐ Hospital
- ☐ Self
- ☐ Other

Referral Agency

_____

Contact Person

_____

Telephone Number

Reason for Referral

EMERGENCY CONTACT:

Last name, First Name

Relationship to Client

Telephone Number

Permission to contact? *(select one)*

- ◯ Yes
- ◯ No

PRIMARY CARE PHYSICIAN:

PCP

- ☐ Client does not have PCP

Primary Care Physician

Office Location

Telephone Number

Date of Last Physical Exam

MEDICATION LIST:

Medication

- [ ] Client does not take medication

REASON FOR REFERRAL:

In your own words, please tell us why you are seeking services:

What day and time works best for scheduling appointments?

Have you recently been hospitalized for a psychiatric issue?

- [ ] Yes
- [ ] No

If yes, when and where?

Do you currently or have you ever had an addition to drugs, alcohol or anything else?

- [ ] Yes
- [ ] No

If yes, explain:

Are you currently a safety risk to yourself or others?

- [ ] Yes
- [ ] No

If yes, explain: