Professional Psychiatric Referral Form for Avenues to Wellness @ Walnut Avenue Associates

DATE OF REFERRAL:	

SERVICE DESIRED:		Psychiatric Services

Include chief complaint, presenting problems and diagnosis in the field to the right.	
*Important info. Please include current labs	Is the patient prescribed an Opiate? Circle YES or NO (The FDA does not allow Benzodiazepines and Opiates together.) Does the individual have Mental Retardation, Autism, Aspergers, PDD, Developmental Delays or an IQ less than 70? If yes, please circle or write in.

CLIENT DEMOGRAPHIC			
Name:			
Address:			
Home Phone:		Date of Birth:	
Cell Phone:		Gender:	
Work Phone:		Race:	
Social Security Number:		Marital Status:	

INSURANCE INFORMATION:	
Medicaid Number:	
Private Insurance Name and Phone Number	
Private Insurance Behavioral Health Name and Phone Number	
Private Insurance ID and Group Number	
Private Ins, Policy Holders Name, SSN, DOB	

LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE/POA INFORMATION (If Applicable)					
Name:				Relationship:	
Address:					
Home Phone:		Cell Phone:		Work Phone:	

LIST CURRENT MEDICATIONS AND DOSES: REQUIRED Can be a pharmacy print out or medical records

CURRENT SERIVICE PROVIDERS:	
MHSS PROVIDER:	
PRIMARY CARE:	
PSYCHIATRIST:	
OUTPATIENT COUNSELOR:	
OTHERS:	

REFERRING PARTY NAME:		REFERRING AGENCY:	
MAILING ADDRESS:			
TELEPHONE NUMBER:		E-MAIL ADDRESS:	
FAX NUMBER:			

OFFICE USE:

PRE-AUTH NEEDED? (YES OR NO):		ACTIVE INSURANCE COVERAGE? (YES OR NO):	
DATE PRE-AUTH REQUESTED:		PATIENT COPAY:	
DATE APPROVAL RECEIVED:		PATIENT COINSURANCE:	
		PLAN DETAILS:	
APPOINTMENT (DATE/TIME):		MISC:	