



Psychiatry Referral Form

Practice Information

Practice Name: _____

Fax: _____ Phone: _____

Email (secure): _____

Address: _____

Patient Information

Patient Name: _____

Date of Birth: ____ / ____ / ____

Preferred Name: _____

Pronouns: _____

Phone: _____ Email: _____

Address: _____

Patient is aware of and consents to this referral

Patient prefers to be contacted directly by the psychiatry practice

Insurance Information

Insurance Carrier: _____

Member ID: _____

Group Number: _____

Self-Pay / Out-of-Pocket

Insurance verification pending

Insurance not accepted by psychiatry practice (patient aware)

Referring Provider Information

Referring Provider Name: _____

Credentials: _____

Practice / Organization: _____

Phone: _____ Fax: _____

Email: _____

Reason for Referral

(Check all that apply)

- Diagnostic evaluation
- Medication management
- Second opinion / consultation
- Treatment-resistant symptoms
- Medication review / optimization
- Transition of psychiatric care
- Other: _____

Clinical Information (Minimum Necessary)

Presenting concerns / symptoms:

Current psychiatric diagnoses (if known):

Current psychiatric medications & doses:

Relevant medical conditions:

History of substance use disorder: No Yes (details): _____

Safety considerations:

- No known safety concerns
- History of suicidal ideation
- History of suicide attempt
- History of violence toward others
- Other: _____

Urgency of Referral

- Routine
- Semi-Urgent (within 2–4 weeks)
- Urgent (within 72 hours)
- Crisis — *patient directed to emergency services*

This referral does not substitute for emergency evaluation.

If the patient is in crisis, they have been instructed to call 988 or go to the nearest emergency department.

Requested Services (if applicable)

- General psychiatry
- Psychopharmacology consultation
- Long-term medication management
- Short-term stabilization
- Telepsychiatry (if available)

Records Included

- Medication list
- Recent progress notes
- Labs
- Discharge summary
- Psychological testing
- Other: _____

Authorization & Acknowledgments

By submitting this referral, the referring provider affirms that the above information is accurate to the best of their knowledge and shared in accordance with HIPAA's **minimum necessary** standard.

This referral does not guarantee acceptance into care.

Acceptance is contingent upon clinical appropriateness, capacity, licensure, and insurance considerations. Please fax to 360-209-8565.

Referring Provider Signature: _____

Date: ____ / ____ / ____

This form contains protected health information intended solely for treatment coordination. If received in error, please notify the sender and securely destroy the document.