



## 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.*