

Referral to Mental Health Services

Date of Referral: _____

From: _____

Address: _____

Phone: _____ Fax: _____

To: _____

Address: _____

Phone: _____ Fax: _____

Patient: _____

DOB: _____

Phone #: Home _____ Work _____

Insurance carrier: _____

Policy ID #: _____

Plan authorization #: _____

Contact person (if not Patient)

Name: _____

Phone #: Home _____ Work _____

1. Goals of treatment as identified by patient

A. _____

B. _____

C. _____

2. Recommendations for psychological counseling treatment

Type of therapist: Counselor/Social Worker Psychologist Psychiatrist

Reason for referral: _____

3. Medical history related to psychiatric diagnosis

4. Previous treatment for psychiatric problems

5. Current medications

Drug	Dose	Frequency

Signature – Healthcare Provider

Signature – Patient

Adapted from the MacArthur Toolkit of the MacArthur Foundation Initiative on Depression and Primary Care. Copyright 2003. Trustees of Dartmouth College.