



VERA FRENCH

MENTAL HEALTH REFERRAL FORM

FAX form to 1-563-823-0761

ATTN: INTAKE DEPARTMENT

PLEASE PRINT

Patient Name _____

Date of Birth _____

PATIENT INFORMATION

Soc. Sec # _____

Home Phone _____

Alt. Phone _____

Agency involved _____

Parent Name _____

Parent Foster parent Guardian (CIRCLE)

Parent Soc. Sec# _____

Parent Date of Birth _____

FINANCIAL/INSURANCE INFORMATION

Primary Insurance _____

Phone _____

Policy# _____

Group# _____

Name of Insured _____

Secondary Insurance _____

Phone _____

Policy# _____

Group# _____

Name of Insured _____

Medicaid Status

Current

Eligible

Application pending

Not applied

REFERRAL SOURCE

Referral Source _____

NPI # _____

Address _____

Office Phone _____

Office Fax _____

Contact Person _____

Patient aware of referral YES NO

REASON FOR REFERRAL

Reason for Request/Specific Question to be answered:

Diagnostic Impression:

Mood disorder	ADHD	Adjustment disorder
Psychosis	Behavioral disorder	Marital issues
Anxiety/PTSD	Parenting issues	Personality disorder
Suicidal thoughts	Violent Behavior	Self-injurious behaviors

Requests For:

Therapy	Consult only: (CIRCLE) Psychiatrist Therapist	Group:
Med Management	Consult and Treat: (CIRCLE) Psychiatrist Therapist	Testing:
Behavior management	Adult Partial Program	Other:

HEALTH HISTORY

Current Medications:

Medication	Dose	Duration	Effect

****please attach past and present medication list if available****

Past Medical History:

YES	NO	Please list if 'YES'
		ALLERGIES:
		Head Trauma, Developmental Disability, Seizure Disorder
		Liver disease:
		Renal disease:
		Heart disease:
		Metabolic disease:
		Thyroid diseases:
		Diabetes:
		Immunological disease:

OFFICE USE ONLY

PATIENT SCHEDULED: _____ (DATE/CLINICIAN)

PATIENT NOT SCHEDULED: **Unable to contact** **Declined services**