NORTHPOINT PSYCHIATRIC CONSULTANTS, LLC

REFERRAL FORM

Referral Date: ___________________

Referral Source: ____

Phone: ___________________ Email: ____

Address: ____

PATIENT INFORMATION

Name: ____ DOB:

Phone: ________________________________

Email: ____

Address: ____

Insurance Plan Name: ____

Policy Holder Name: ____

Policy Number: ________________________ Group Number: ________________________

Policy Holder DOB: ____________________ Policy Holder SS#: _____________________

Reason for Referral (specific symptoms, behaviors, presenting issues):

____

Previous psychiatric services:	Y	N
Currently taking psychiatric medication:	Y	N
Currently prescribed suboxone/methadone:	Y	N
DCF involvement or legal issues:	Y	N
Psychiatric hospitalizations within the last 6 months:	Y	N
Therapy needed:	Y	N
Medication management needed:	Y	N

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