

Outpatient Referral Form

Referral Source Information:

Person Making Referral: _____ Date: _____

Referral Organization: _____ Phone #: _____

Office Contact Person: _____ Fax #: _____

Patient Information:

Patient Name: _____ Date of Birth: _____

Parent/Guardian (if applicable): _____ Phone #: () _____

Primary Insurance: _____ Subscriber Name: _____

Patient Referred for: (check one or more boxes below)

- Psychotherapy/Counseling** – Depression, Anxiety, Substance abuse, Insomnia, Behavior change (smoking cessation, healthy eating, etc.), Personality disorder, Relationship issues, Stress management, etc.
- Psychological Testing** – ADHD, Learning disability, Autism, Brain injury, Dementia, Pre-surgical testing, etc.
- Psychiatry** – Medication evaluation and/or management
- Substance Abuse** – Assessment to determine level of care needed (Outpatient, IOP, PHP, Sub-Acute Detox)

Please explain: _____

Patient's preference for clinician, if any (gender, age): _____

PHQ-9 Score (If available): _____

Patient's Release of Information: I authorize this referral source to share this form with Pine Rest for the purpose of discussing and scheduling my appointment. An additional release of information will be required to discuss treatment.

Patient signature: _____ Date: _____

Please check box if patient provided verbal consent.

**Please fax this form to 877-242-6963 or call Central Access at 866-852-4001.
Pine Rest staff will contact the patient within two business days.**

For Pine Rest Use Only

Please fax form back to referral source within 72 hours of request.

Referral Status: Appointment Scheduled: Date: _____

Clinic: _____ Clinician: _____

Patient unable/declined (circle) to schedule: _____

Not scheduled due to: _____

Pine Rest employee completing this form: _____