PINE REST Christian Mental Health Services

BEHAVIORAL HEALTH REFERRAL

Referring Provider: _____ **Date:** _____

Medical Practice/Group: _____ **Phone#:** _____

Office Contact Person: _____ **Fax#:** _____

Patient & Insurance Information:

Patient Name: _____ **Date of Birth:** _____

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

Primary Insurance: _____ **Subscriber Name:** _____

Reason for Referral: _____

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

☐ **Psychotherapy** – *Anxiety, depression, substance abuse, behavior change (smoking cessation, weight loss, etc.), personality disorder, sexual dysfunction, eating/sleep disorders, relationship issues, stress management, etc.*

☐ **Psychological Testing** – *Clinic-based assessments for ADHD, cognitive functioning evaluation, pre-surgical evaluation, personality testing, learning disorders, other medical and behavioral health issues*

☐ **Psychiatry** – *Medication evaluation and/or management*

Patient's Release of Information: ***I authorize my physician's office to share this form with Pine Rest for the sole purpose of scheduling my first appointment. This authorization expires 30 days from this date. I understand that I can rescind this authorization at any time.***

Patient/Guardian signature: _____ Date: _____

Please fax completed form to: **641-621-1493**

Phone: (641) 628-9599

FOR PINE REST USE ONLY

Please fax form back to medical office within 72 hours of request.

Referral Status:
- ☐ Appointment Scheduled for following date: _____
  Clinic:_____ Clinician: _____
- ☐ Patient unable to schedule due to _____
- ☐ Patient declined to schedule due to _____
- ☐ Not scheduled due to: _____

Pine Rest employee completing this form: _____