



## Referral for Psychological Services

Date of referral: \_\_\_\_\_ Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Insurance or EAP: \_\_\_\_\_ Is the patient accepting of the referral?  Yes  No

Contact Preference:  Patient will call for appointment  
 Please call patient to arrange appointment (Phone: \_\_\_\_\_)

### Reason for Referral (check all that apply)

<b>Mood Problems:</b>	<input type="checkbox"/> Anxious/Worried <input type="checkbox"/> Stressed/ Tense <input type="checkbox"/> Extreme Reactions	<input type="checkbox"/> Depressed/Sad <input type="checkbox"/> Hopeless/Helpless <input type="checkbox"/> Feeling "Stuck"	<input type="checkbox"/> Mood Swings <input type="checkbox"/> Manic/Euphoric <input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Angry/Irritable <input type="checkbox"/> Overwhelmed <input type="checkbox"/> Inappropriate Guilt
<b>Behavior Problems</b>	<input type="checkbox"/> Non-Adherence <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Unhealthy Eating Habits <input type="checkbox"/> Unhealthy Sleep Habits	<input type="checkbox"/> Communication Skills <input type="checkbox"/> Interpersonal Problems	<input type="checkbox"/> Impulsive Behavior <input type="checkbox"/> Medication Seeking
<b>Thought Process</b>	<input type="checkbox"/> Insightful <input type="checkbox"/> Lacks Insight	<input type="checkbox"/> Attention Problems <input type="checkbox"/> Tangential/Circumstantial	<input type="checkbox"/> Obsessive <input type="checkbox"/> Self-Critical	<input type="checkbox"/> Bizarre/Unusual <input type="checkbox"/> Memory Problems
<b>Medical &amp; Health Related</b>	<input type="checkbox"/> Complaints disproportionate to organic pathology <input type="checkbox"/> Unhealthy Lifestyle <input type="checkbox"/> Poor Self-Care	<input type="checkbox"/> Difficulty coping with/accepting illness <input type="checkbox"/> Family/relationship stress undermining health/recovery	<input type="checkbox"/> Multiple physical complaints in the absence of physical findings <input type="checkbox"/> Keeps bringing up complaints already addressed <input type="checkbox"/> Not making progress despite improved organic status	
<b>Other Issues</b>	<input type="checkbox"/> Work Stress	<input type="checkbox"/> Family/Relationship Stress	<input type="checkbox"/> Financial Problems	<input type="checkbox"/> Bereavement/Loss
<b>Motivation</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Not sure
<b>Supports</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Not sure

Requested Service:  Individual Therapy  Marital/Family Therapy  Evaluation/Consultation/Testing

Risk Assessment:  Routine  Urgent (appt. within 48-72 hrs.)  Emergent (appt. within 24 hrs.)

Medical Condition(s): \_\_\_\_\_  
 \_\_\_\_\_

Medications: \_\_\_\_\_  
 \_\_\_\_\_

Additional Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please Fax Referral to 610.873.4715**