SNBCare
Spectrum Neuro Behavioral Care

SNBCare Framingham MA Office
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Framingham, MA 017028264
Phone: (781) 666 2711 | Fax: (781) 666 2712

REFERRAL FORM

Patient Information

Name: | Date of Birth:
Address: | Gender:
Telephone #1:
Marital Status: | Telephone #2:
Language: | Email:

Contact Person (If under 18 or has legal representative)

Name: | Relationship:
Telephone #:

Contact person to arrange appointment:

☐ **Patient**
☐ **Referring Physician**
☐ **Other:**

Name: | **Relationship:**
Phone #:

Insurance Information

Insurance Type: | Member ID:
Primary Insurance Holder: | Relationship to Insured:

Referring Physician/ Source

Name: | Practice/ Hospital:
Address:
Telephone #: | Fax #:
Is the patient agreeable with the referral? ○ Yes ○ No

Reason for Referral

☐ TMS
☐ PSYCHIATRIC EVALUATION
☐ MEDICATION MANAGEMENT
☐ THERAPY

1. **Presenting Problem** (e.g. Current symptoms, presenting problem, history)

2. **Substance Abuse** (Current substances and frequency of use): Does patient want help with this issue? ○ Yes ○ No

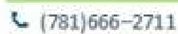
3. **Risk Issues** (History of suicide attempts, selfinjurious behavior, violent behavior, legal issues, recent hospitalization)

4. **Medications** (Psychiatric and nonpsychiatric or attach list)

5. **Relevant Medical/Developmental History** (e.g. disabilities, intellectual delays, allergies, active medical diagnosis). **Please attach last medical note.**

Completed by: Date:

PLEASE FAX TO: (781) 666 – 2712 ATTENTION: SNBCare Intake Dept.



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