SPECTRUM NEURO BEHAVIORAL CARE

REFERRAL FORM

Patient Information

First Name: Last Name

Date of Birth: Gender: M / F / Preferred Not to say

Street Address: State

City: Zip Code:

Telephone#1: Telephone#2:

Marital Status: Language:

Email:

Contact Person (If under 18 or has legal representative)

Name: Relationship:

Telephone #:

Contact person to arrange appointment:

- ☐ **Patient**
- ☐ **Referring Physician**

Other: Name: Phone # Relationship:

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? Y / N

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? Y / N

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

4. **Medications** (Psychiatric and non-psychiatric or attach list)

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

Completed by: _____ Date: _____

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