OUTPATIENT REFERRAL FORM

PATIENT INFORMATION				
Name: Last, First, Middle			Maiden Name:	
Address:		City:	State:	Zip:
Primary Language:	Interpreter Needed: ☐ Yes ☐ NO	Home Phone: ( ) -	Cell Phone: ( ) -	
Gender: ☐Male ☐Female	Race:	Marital Status:	Currently Receives MH Services ☐ YES ☐NO	
Social Security Number:	Date of Birth:	Job/School:	Position/Grade:	
Primary Care Provider:		Address:		Phone:

RESPONSIBLE PARTY				
Name:			Relationship to Patient:	
Address:		City:	State:	Zip:
Primary Language:	Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -	

REFERRAL SOURCE			
Referred By: ☐Inpatient ☐Outpatient ☐Housing Provider ☐Peer Services ☐Family/Friend ☐CPEB/ER/Em.Svcs ☐Correctional Facility ☐OBH ☐Self ☐Case Management ☐ Other _____			
Date of Referral:	Agency:	Contact Person:	
Email:		Phone: ( ) -	Fax: ( ) -
Court Ordered: ☐ Yes ☐ NO	Is the individual Aware of this referral? ☐ Yes ☐ NO		
Discharge Date:	Services Requesting: ☐ CPST ☐ PSR ☐ Crisis Intervention ☐ Anger Management ☐ Independent Living ☐ Substance Abuse ☐ Other _____		

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SYMPTOMS AND BEHAVIORS			
☐ Anxiety, irritability, or restless ness	☐ Argumentive or Uncooperative	☐ Phobias	☐ Depression
☐ Poor adjustment to a medical condition	☐ Bi-polar	☐ Substance Abuse	☐ Emotional Outbursts
☐ Impulsive	☐ Sleep problems or disorders	☐ Exacerbation of health problems	☐ Decline in functioning
☐ Hallucination	☐ Personality disorder	☐ Inappropriate sexual behavior	☐ Aggressive or disruptive behavior
☐ Schizophrenia	☐ Self-abuse or mutilation	☐ Social isolation or withdrawal	☐ Danger to self or others
☐ Suicidal Ideation	☐ Poor appetite or significant weight fluctuation	☐ Non-compliant with medical or nursing care	☐ Other:

CURRENT MEDICATIONS			
Name	**Dosage**	**Schedule**	**Reason**

Summary of individual's current situation:

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