Restoring Destiny Mental Health Service LLC
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Website: restoringdestinymentalhealthservices.org

Mental Health Services Referral Form

Date of Referral: _____

Referral Source

Referring Provider Name: _____

Agency: _____ Contact Phone: _____

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name: _____

Address (incl. zip code): _____

Address where virtual session will be held: _____

Mailing Address (If different from above): _____

Cell Phone #: _____ Social Security #: _____

DOB: _____ Sex: _____ Race: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Gender Identity: _____ Pronouns: _____

Sexual Orientation: _____ Do you Identify as Disabled? _____

If Yes, Do You Need Social Security/Disability Forms Completed By Us? ☐ Yes ☐ No

Medical Insurance Type: _____ Current Insurance Provider: _____

Primary Subscriber Name: _____

Policy Number: _____ Policy Type: _____

Coverage Start Date: _____ Coverage End Date: _____

Is This Insurance Provided By Your Employer? ☐ Yes ☐ No

Do You Have A Secondary Insurance Provider? ☐ Yes ☐ No

Secondary Insurance Provider: _____

Primary Subscriber Name: _____

Policy Number: _____ Policy Type: _____

Coverage Start Date: _____ Coverage End Date: _____

Is This Insurance Provided By Your Employer? ☐ Yes ☐ No

Emergency Contact Name: _____

Relationship to Patient: _____ Contact #: _____

Address: _____ Email Address: _____

Primary Care Physician Name _____

Clinic Name: _____ Address: _____

Telephone Number: _____ Date Of Last Appointment: _____

Veteran: ☐ Yes ☐ No

If Yes, Provide Choice Of Branch Of Service (Ie, Army, Navy, Air Force,Marines)

_____

Check Yes If Involved In Combat: ☐ Yes ☐ No

If Yes, Name Conflicts: _____

CLINICAL INFORMATION

Reason for Referral:

_____

Diagnosis (list confirmed if known, if not list suspected)

Primary Psychiatric Diagnosis: _____

Relevant Medical Diagnoses: _____

Past Psychiatric History (hx) and Treatment (please check appropriately)

Hx of violence? ☐ No ☐ Yes, details _____

Hx of suicide attempts? ☐ No ☐ Yes, details _____

Hx of psychiatric hospitalizations? ☐ No ☐ Yes, details _____

Previous symptoms and diagnoses: _____

Current Psychiatric Treatment & History

Current Symptoms: _____

Current suicidal / homicidal thoughts? ☐ No ☐ Yes, details _____

Does patient have a current outpatient mental health provider? ☐ No ☐ Yes, details

_____

Reason not returning: _____

Additional Information: _____

Current Psychiatric Medications (name & dose, attach list if preferred)

_____