PATIENT REFERRAL FORM

PATIENT INFORMATION * =Required Field

Patient Name: *	Date of Birth: (mm/dd/yyyy):*	SS #: *
Patient Provided Consent for PsychBC to Contact: **Yes** ☐ **No** ☐		
Primary Phone: *	Alternate Phone:	Gender: *
Address: *		
City: *	State: *	Zip: *
Insurance Name/Plan: *		
ID #: *	Group #: *	Effective Date:
Policy Holder Name: *	Date of Birth: (mm/dd/yyyy):	Relation to Patient:
Reason for Admission: *		

Primary Diagnoses: *	Mental Health Medications: *	Discharge Date: *
Past or current issues with substance use? (*If yes, which substance(s)*): *		
Specific Requests?		

PsychBC intake staff will try to honor a patient request; however requests may not always be feasible due to availability, location, etc.

REFERRAL INFORMATION:

Referring Practice/Physician: *	Department:	Phone #:
Email Address:	Fax Number: *	
Primary Care Physician:		

APPOINTMENT REQUESTS (please check all that apply): *

Individual Therapy ☐ Medication Management ☐

Assessment for Intensive Outpatient Program ☐ Occupational Therapy ☐

Nutritional Counseling ☐

FOR PSYCHBC USE ONLY

Appointment Date: _____Time: _____Provider:_____ Location:_____

Appointment Date: _____Time: _____ Provider:_____ Location:_____

For additional questions, please call the PsychBC Intake Department at 844-468-5050, ext. 1.
Thank you for referring to PsychBC.
FAX NUMBER: 216-514-4855