Arnold Pro Services, LLC
Tiffany Arnold, LCSW, CCTP II

Mental Health Referral Form

Date of Referral: _____

Referral Source

Referring Provider Name _____ Agency _____ Contact Phone # _____

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name _____ Medical Record Number (if applicable) _____
Address (incl. zip code) _____
Home Phone # _____ Cell Phone # _____ Social Security # _____
DOB __/__/____ Sex _____ Race _____ Marital Status Single Married Divorced Widowed
Insurance Type: _____ Policy Number _____

Emergency Contact Name _____ Relationship to Patient _____ Contact # _____
Primary Care Physician _____ Clinic Name _____ Phone _____
Current Type of Housing (e.g., group home): _____ Veteran Yes No

CLINICAL INFORMATION

Reason for Referral _____
_____

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

Former patient in clinic referred to? No Yes, details _____ 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)

_____
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_____
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_____

Signature of Referral Source _____ Date / Time _____