WESTERN MICHIGAN UNIVERSITY
SCHOOL OF MEDICINE

Psychiatry Clinic Patient Referral Form

1717 Shaffer Street, Suite 010
Kalamazoo, MI 49048
Phone: (269) 337-6373 Fax: (269) 337-6376

DATE: _____

PATIENT NAME: _____ DOB: _____

PATIENT ADDRESS: _____ Sex: _____

_____ SS#: _____

_____

COUNTY: _____

PATIENT (Daytime) PHONE: _____ Secondary Phone: _____

IF PATIENT IS A MINOR – PARENT/GUARDIAN NAME: _____

RELATIONSHIP TO PATIENT: _____

*** A first appointment is for assessment purposes only and does not represent a commitment for services. Once the patient is established and is no longer in need of specialty psychiatric care, the patient may be referred back to the primary care provider. By initialing this line the primary care physician agrees to accept their patient back for continued care. _____

REFERRING PRIMARY CARE PHYSICIAN

Provider Practice Name:
Physician Name:
Office Contact:
Phone:
Fax:
Address:

PRIMARY INSURANCE COVERAGE	**SECONDARY INSURANCE COVERAGE**
Insurance Co:	Insurance Co:
Cardholder:	Cardholder:
Cardholder's DOB:	Cardholder's DOB:
Cardholder's SS#:	Cardholder's SS#:
Cardholder's relationship to patient:	Cardholder's relationship to patient:
Policy#:	Policy#:
Group#:	Group#:

CHECKLIST FOR INFORMATION REQUIRED WITH THIS REFERRAL FORM:

(INCOMPLETE FORMS WILL NOT BE PROCESSED)

1. _____ **Copy of patient's insurance card(s) (FRONT & BACK)**
2. _____ **Copy of the last two progress notes clarifying the cited purpose of this referral**
3. _____ **Current med list and allergies / adverse reactions**
4. _____ **Completion page two of this referral form**

WESTERN MICHIGAN UNIVERSITY
SCHOOL OF MEDICINE

A. WHY IS A SPECIALIST IN PSYCHIATRY BEING SOUGHT (Describe the reason(s), including changes in patient's emotional status, changes in patient's ability to function, etc.)**:**

B. CURRENT DIAGNOSES:

C. COMMUNITY MENTAL HEALTH: Has patient ever been under the care of CMH? Yes ☐ No ☐
If yes, dates of service / reason for termination:

D. MENTAL HEALTH TREATMENT HISTORY:

Psychiatrist: **Current ☐ Past ☐ Dates:**

Therapist: **Current ☐ Past ☐ Dates:**

E. PAST PSYCHIATRIC HOSPITALIZATIONS (Date(s) & Hospital):

F. PERTINENT MEDICAL HISTORY:

G. LEGAL HISTORY (including probation):