WMED HEALTH

THE CLINICAL PRACTICE OF WESTERN MICHIGAN UNIVERSITY
HOMER STRYKER M.D. 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: _____ Patient DOB: _____

Patient Address: _____

Street City State Zip

Sex: _____ Gender Identity: _____

Patient Social Security #_____ County: _____

Phone: _____ Cell # _____

If Patient is a Minor- Parent /Guardian Name: _____DOB:_____

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 provide. The primary care provider agrees to accept their patient back for continued care.

Does the patient need an Interpreter ☐ Yes ☐ No If yes, what type of language? _____

Primary Insurance: _____ **Secondary Insurance: _____**

Policy # _____Group # _____ **Policy # _____Group # _____**

Policy Holder: _____DOB: _____ **Policy Holder: _____ DOB: _____**

Referring Physician: _____ Practice Name: _____

Full Address_____

Office Phone # _____ Office Fax: _____

Office Contact Person _____ Phone/ Extension _____

******* Checklist for information required with this referral Form********

- **Copy of patient's insurance card (s) front and back**
- **Copy of the last two progress notes clarifying the cited purpose of this referral**
- **Current medication list / adverse reactions**
- **Completed page two of this referral form**

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1. Why is a specialist in Psychiatry being sought?

Current Diagnoses _____ **CPT Code for Primary Psychiatry dx** _____

_____ _____ _____

2. Mental Health History:

   Psychiatrist _____ ☐Current ☐Past Dates _____

   Therapist: _____ ☐Current ☐Past Dates _____

3. Community Mental Health History:

4. Psychiatric Hospitalizations

   Locations: _____ Dates: _____
   Locations: _____ Dates: _____
   Locations: _____ Dates: _____

5. Pertinent Medical History:

6. Legal History: