New Patient Intake Referral Form

Date of Inquiry/Referral_____

Inquiry/Referral Source ☐Hospital ☐Primary Care Provider ☐Insurance Provider ☐Drug/Treatment Program

☐Family/Friend/Co-Worker ☐Internet/Social media ☐Other(specify)_____

Inquiry/Referral Source Information_____

Reason for Inquiry/Referral (Issue/Symptoms/Concerns) _____

Client Name_____ Preferred Name_____ DOB_____

If Client is a Minor- Name(s) of Parent/Guardian_____

Address _____ Phone_____

Emergency Contact Name and Number _____ Relation_____

Primary Care Provider Name and Number _____

Preferred Pharmacy_____ Phone Number_____

Insurance Provider _____ Member ID_____

Have you previously received therapy ☐ Yes ☐ No If yes, where_____

Have you previously been treated for mental health with medication ☐ Yes ☐ No

If yes, treating provider and medications prescribed_____