DELTA FAMILY CLINIC SOUTH P.C.

Referral Request Form

Please complete form to the best of your ability and fax to Delta Family Clinic South P.C. at (810) 630-9107. Incomplete information may result in form being returned to sender, and/or delayed patient care. Thank you for your cooperation!

Referral Source Information

Company/Organization: ____

Physician/Referring Provider (Name): ____

Office Contact Person (Name): ______________________________ **Referral Date:** ____________________

Referral Phone: (________) ________________________ **Referral Fax:** (________) ________________________

Patient Demographics

Patient Name: ____ **DOB:** ________________ **Gender:** M / F

Parent(s)/Legal Guardian(s) Name: ____

Parent(s)/Legal Guardian(s) Relationship to Patient: ☐ Patient is their own guardian ☐ Parent of minor

☐ Parent of adult client ☐ Legal guardian ☐ Other Relation ____________________________________

Primary Phone: (________) ______________________ **Secondary Phone:** (________) ______________________

Current Address: ____

Primary Insurance/Bill Type: ______________________ **Primary Insurance Member ID:** ______________________

Secondary Insurance: __________________________ **Secondary Insurance Member ID:** ____________________

Tertiary Insurance: ____________________________ **Tertiary Insurance Member ID:** _____________________

Clinical Information

Referral Type: ☐ Medication Management ☐ Psychological Evaluation ☐ Neuropsychological Evaluation

☐ Bariatric Evaluation ☐ Spinal Evaluation ☐ Individual Therapy ☐ Family Therapy ☐ Couples Therapy

Referral Status: ☐ Routine ☐ Urgent

Current Diagnosis: ____

Current Symptoms/Observations: ____

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____

Current Psychiatric/Psychotropic Medications (Medication name, Mg, Directions, and Quantity): (*Attach medication list if preferred)*

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____

Psychiatric History & Treatment

History of Violence? Y / N If yes, please explain: ____

____

***History of Suicidal/Homicidal Ideations?** Y / N If yes, please explain: ____

____

History of Psychiatric Hospitalizations? Y / N If yes - Date Admitted, Facility Name, & Reason for Admittance: _____________

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If patient is experiencing CURRENT suicidal/homicidal ideations, please refer patient to the nearest hospital emergency room. Delta Family Clinic South P.C. is only equipped to facilitate out-patient aftercare.

Patient's Release of Information:

I authorize this office/organization to share this referral form with Delta Family Clinic South P.C. for the purpose of discussing and scheduling my appointment. I am aware that an additional release of information will be required to discuss anything in relation to treatment at Delta Family Clinic South P.C.

Patient Signature: ____ **Date:** ______________________________

Additional to this form, please send any patient information that could be beneficial for coordination of care, i.e. applicable medical records, notes from the referring provider, etc. You may fax this referral form and any additional forms to (810) 630-9107. Our office will contact the patient within 5-7 business days of receiving the referral to schedule an appointment unless it is an emergency.

Delta Family Clinic South P.C. appreciates your cooperation!

For Delta Family Clinic South P.C., use only:

Referral Status:

____ Appointment Scheduled: Date: ___________ Time: ___________ Clinician: ________________________________

____ Patient not scheduled due to: ____

DFC Employee Name (who scheduled): ____