



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: _____

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

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: _____

**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.*

Please note: No HIPAA protected information can/will be released without a signed release of information by the patient/patient guardian in our office.