DELTA FAMILY CLINIC SOUTH P.C.

Delta Family Clinic
Treatment you can trust!

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)*

_____

_____

_____

Dose the patient have a history of substance abuse? □ Yes □ No

Does the patient have a current substance abuse problem? □ Yes □ No

If yes to either question, please list type of substance abuse, substances used, and date of last use: _____

_____

_____

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.