PROVIDER REFERRAL FORM FOR PSYCHIATRIC CARE

Please complete and fax to 360-255-2504

Date of referral _____ Referred to _____

Referring Provider's Name _____ Phone _____ Fax _____

*If your patient establishes care, **please circle** the method that you would you prefer to use for consultation between yourself and our Psychiatrists.*

Phone or voicemail *Fax* *Video Teleconference (Dr. Kostial and Dr. Arndorfer only)*

Client Name _____ Date of Birth _____

Client Phone Number _____ Insurance Co. _____

Primary Care Provider _____ Therapist _____

Please describe the current clinical details regarding this patient: _____

_____

_____

_____

How would seeing a psychiatrist benefit this patient? _____

_____

Does this patient have a history of or current substance **abuse** that you are aware of? If so, please specify.

_____

_____

Has the patient been diagnosed with, or do your suspect, a personality disorder? Please specify.

_____

_____

Is the patient currently taking psychiatric medications? If known, please list. _____

_____

Has the patient been hospitalized psychiatrically? If so, when? _____

_____

Has the patient had suicide attempts? If so, when? _____

_____