



Web Outpatient Referral Form

Potential Client Information Fax form to 724-439-2667

Name _____

SS# _____ Date of Birth _____ Age _____

Address: _____

Home Phone: _____ Other Phone: _____

OK to call Y N

OK to call Y N

Why are you seeking Outpatient Treatment now? What would you most like help with?

Services currently receiving: _____

Previous treatment history (include inpatient and Op and Dates)

Current/Past D/A Use: _____

Current/Past D/A Treatment: _____

Current/Past Medical Problems: _____

Current meds (include name of Prescribing Physician & Days supply remaining)

Suicidal/Homicidal Thoughts If yes call 724-437-1003

Previous Attempts *Y/N* If so, how? _____

Self-Mutilating Behavior *Y/N* _____ Auditory/Visual Hallucinations *Y/N* _____

Appetite *Good/Fair/Poor* _____ Sleep Pattern *Good/Fair/Poor* _____

Aggressive Behavior *Y/N* _____ Destructive Behavior *Y/N* _____

Thought process: Organized/*Disorganized*/Obsessive/*Other* _____

Mood: Stable/*Unstable*/Depressed/*Tearful*/Agitated/*Manic*/Other _____

Behavior: Cooperative/*Uncooperative*/Aggressive/*Loud*/Quiet/*Other* _____

Interested in therapy *Y N* Psychiatrist *Y N*

Insurance 1 _____ Insurance 2 _____

Name _____ Name _____

Policy/Group # _____ Policy/Group# _____

