CHESTNUT RIDGE
COUNSELING SERVICES, INC
"We Treat Each Person As If They Are Family"

Outpatient Referral Form For Physician to Physician Coordinated Care

Please fax this form to 724-439-8487
Please call 724-437-HELP (4357), with any questions to speak directly to a member of our staff.

Services Requested: Psychiatry Consult/Counseling

Last Name: _____ First Name: _____

Middle Initial: _____ Maiden Name: _____

DOB: _____ SSN: _____ County: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Address:

_____

Gender: _____ Race: _____

Deaf: ☐ Yes ☐ No Veteran: ☐ Yes ☐ No Smoker: ☐ Yes ☐ No

Emergency Contact (name, relationship, & phone number):

_____

Date of Referral: _____ Who is referring: _____

Referring Phone Number: _____ Discharge Date: _____

Any Custody Order: _____

Reason for Visit:

_____

_____

Suicidal: ☐ Yes ☐ No Homicidal: ☐ Yes ☐ No

Allergies: _____

Insurance Name: _____ ID Number: _____

Group Number: _____ Ins Phone Number: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber SSN: _____

Please send a list of discharge medications and copies of all labs, EKGs, and admitting evaluation.