



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.