Outpatient Referral Form for Physician to Physician Coordinated Care
Please email this form to referrals@crcsi.org
Please call **724-437-0729**, 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: _____

Date Of Birth: _____ Deaf ☐Yes ☐No

SSN: ____-___-_____ County of residence: _____

Veteran ☐Yes ☐No Smoker ☐Yes ☐No

Home Phone: _____ Cell Phone: _____

Gender: _____ Race: _____

Home Address: _____

Date of Referral: _____ Who is referring: _____

Referring Agency Phone number: _____ Discharge Date:_____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Emergency Contact Relationship: _____

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 if applicable a list of discharge medications and copies of all labs, EKGs, and admitting evaluations.