MEDICAL CLINIC
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Inspire-Psyche
HEALTH SERVICES PLLC

REFERRAL FORM

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ **Age:** _____

Parent's Name: _____

Parent's Primary Language: **English:** ☐ **Spanish:** ☐ **Others:** _____

Phone Number: _____

Insurance (Circle one): **Medicaid** **CHIP** **Private Insurance** **Cash**

Insurance ID Number: _____

Doctor's Office Name & Number: _____

_____

Refer For:

Do any of your immediate family members have a history of the following?

- ☐ **Depression** ☐ **Anxiety Disorder** ☐ **Anxiety Disorder** ☐ **Schizophrenic Spectrum**
- ☐ **Dementia** ☐ **Insomnia** ☐ **ADHD Symptoms** ☐ **OCD** ☐ **Grief**
- ☐ **Trauma PTSD** ☐ **Personality Disorders** ☐ **Addiction** ☐ **Psychological Testing**
- ☐ **Pharmacotherapy** ☐ **Brief Psychotherapy** ☐ **SPRAVATO**

REASON FOR TODAY'S VISIT

- **Symptoms/Concerns:** _____
- **Duration of Symptoms:** _____
- **Previous Treatments (if any):** _____

Doctor's Signature: _____ **Date:** _____

For Official Use Only

Thank you for this referral of your patient.

Unfortunately, we were unable to complete the evaluation requested above due to the following:

☐ **We don't accept that insurance** ☐ **Unable to contact parent** ☐ **Parent never returned our calls**
☐ **We scheduled evaluation, but patient did not show up** **Other:** _____