GAP GERIATRIC & ADULT PSYCHIATRY
CLINICAL CARE & RESEARCH CENTER
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# PROVIDER REFERRAL FORM

→ → REFERRALS WILL NOT BE ACCEPTED WITHOUT SIX MONTHS TO ONE YEAR OF MEDICAL HISTORY ← ←

Referring Provider: _____ Date: _____

Provider's Phone: _____ Specialty: _____
(ie: PCP/Cardio/Neuro/Hospital)

Patient's Name: _____

D.O.B.: _____ Gender: Male___ Female____

Primary #: _____ Other #: _____

Primary Insurance (name & ID#): _____

Secondary Insurance (name & ID#):_____

**Past Psych HX:** YES __ NO __ Diagnosis: _____

**Cognitive Status:** Questionable _____ Impaired_____ Intact _____

**Psychiatric Concerns:** (check all that apply)

Depression ____ Suicidal____ Hallucinations___ Delusions ____

Wandering ____ Anxiety____ Aggression___ Safety Risk ___

Resistive to care____ Verbal abusive____ Other: _____

Notes: _____

_____

Name of Primary Contact (if applicable): _____

Primary #: _____ Other #: _____

Primary Contact: Spouse___ Child___ POA___ Conservator___ Caregiver___ Other ___

This office does not provide emergency services. Our patient relations representative will contact the patient or contact person to schedule an appointment.