GERIATRIC & ADULT PSYCHIATRY
60 Washington Avenue, Suite 203
Hamden, CT 06518

REFERRAL FORM

P: 203-288-0414 F: 203-288-3655

Completion of this form does not guarantee acceptance for psychiatric services.
Please provide medical records to support this referral. ALL records are subject to clinical review.

PATIENT INFORMATION

Name: _____ Phone #: _____

DOB: _____ Age: _____ Gender: ☐ M ☐ F Email: _____

Address: _____ City: _____ Zip: _____

Contact if different than named above: Name: _____ P#: _____

INSURANCE INFORMATION

Primary Insurance: _____

ID #: _____

Referred by: _____

Secondary Insurance: _____

ID #: _____

Specialty: ☐ PCP ☐ Neuro ☐ Psych ☐ Other _____

Reason for referral: _____

MEDICAL PROVIDERS

Primary Care Provider: ☐ Yes ☐ No

If yes, Name: _____

Phone #: _____

Neurologist: ☐ Yes ☐ No

If yes, Name: _____

Phone #: _____

Therapist: ☐ Yes ☐ No

If yes, Name: _____

Phone #: _____

If no, is the patient interested in therapy? ☐ Yes ☐ No

Previous Psychiatric Care Provider: ☐ Yes ☐ No

If yes, Name: _____

Phone #: _____

Substance Hx: ☐ Yes ☐ No

If yes, explain findings: _____

Psychiatric Hospitalizations: ☐ Yes ☐ No

If yes, where/when: _____

Current psych meds: ☐ Yes ☐ No If yes, provide list:

_____

_____

Who is prescribing? _____

PSYCHIATRIC CONCERNS

Does the patient have concerns with:

☐ ADHD/ADD
☐ Anxiety
☐ Bipolar/Mania
☐ Depression
☐ Grief
☐ Insomnia
☐ MCI/Dementia
☐ OCD
☐ Psychosis
☐ Trauma/PTSD

Does the patient have a concern with memory impairment:

☐ Yes ☐ No If yes, explain findings:

_____

_____

_____

Is the patient a fall or wander risk: ☐ Yes ☐ No

ADDITIONAL INFORMATION

Does the patient have reliable transportation? ☐ Yes ☐ No

Has this referral been discussed with your patient/family member? ☐ Yes ☐ No

Additional concerns or support needs:

_____

_____

NOTE: REFERRALS WITHOUT MEDICAL RECORDS WILL CAUSE DELAY.