Northeast Family Services **Psychiatry Services**

Date:_____

Referral Form

Client Name:_____ Sex: ☐ M ☐ F DOB:_____

SSN:_____

Primary Insurance Type: MBHP ____ UBH ____ BCBS ____ Tufts____ Harvard Pilgrim: ____

Other_____

Insurance ID:_____

Policy Holder:_____ Policy Holder DOB:_____

Referral Source

Name/Credentials:_____ Phone:_____

Title:_____

Agency/Affiliation:_____

Insurance Care Advocate/Case Manager:_____ Phone:_____

Primary Contact:_____

Relationship to client:_____ Legal Guardian? ☐ Y ☐ N

Address: _____ Home #: _____

_____ Cell #: _____

_____ Work #: _____

Our center does not provide treatment for alcohol and/or substance abuse. Please have the patient contact their insurance company for available treatment options for these disorders.

What is the client's chief complaint? Please Describe:_____

_____

Circle Severity of problem: MILD MODERATE SEVERE (Hospitalizations or crisis evaluation)

Describe: _____

What is the key question you want addressed?

Diagnosis (DSM V) if known:

Primary Care Physician: Phone Number:

Allergies:

Relevant Medical information:

	Present	Past
Medications:		

Current Therapist

Name/Credentials: Phone:

Title:

Agency/Affiliation:

Other Information:

Please return completed referral forms by Fax: 774-628-9657

For any questions please call at 774-206-1125

Intake for: _____ Completed by: _____
date: _____

Intake form for CHILDREN, TEENS, and adults who are not their own guardian

When setting up appointment, ask person to
A. Arrive at an appointed time 15 minutes before the scheduled appointment to see the doctor to complete essential paper work.

B. And to please bring copies of:

- Any prior inpatient hospital treatment discharge summaries
- Any previous psychological testing and reports
- A complete list of any medications your child is currently taking including non-psychiatric medications. A second list of previous medications that were taken but stopped.

1. Please enter this information about the **primary care practitioner**

Name	MD RN?	Address	Phone #	Fax #	Date of last exam

2. Please enter this information about the most recent **psychiatrist** or prescriber, (if any)

Name	**MD/ RN?**	**Address**	**Phone #**	**Fax #**	**Date of last exam**

3. For ALL **medications** (not just psychiatric) that you now take, please list:

Medication	Pill size	Directions	Purpose/Dx	Prescriber

Intake for: _____ Completed by: _____
date: _____

4. For ALL psychiatric **medications** that you to take, please list:

Medication	Pill size	Directions	Purpose/Dx	Why stopped?

5. In one or two sentences, what is the reason that you are seeking a psychiatric consultation today?

6. What is the **history** of the problems you just described?

7. **Any other major concerns**?

8. **Physical Health:** Are there any **medical diagnoses** or concerns? Any past history of medical illnesses? Allergies? Serious Drug Reactions?

What illness or medical condition?	**Where treated, when?**

Intake for: _____ Completed by: _____
date: _____

9. **Family Mental Health/Substance Use:** Does any one in the family have diagnoses of: ADHD, Anxiety DO, Bipolar, Depression, schizophrenia, substance use (list each drug separate), suicide attempt, other (explain)

Who has it?	Diagnosis	When did it start?	Is the condition still active?	Is it being treated?

10. **Prior Treatment History:** Please list all previous INPATIENT treatment facilities

Date Admitted	Date D/C	Name of facility	Reason for admission	Outcome

11. **Current** outpatient treaters:

Degree	Name	Frequency of appts.