PATIENT REFERRAL FORM

Referring Facility: _____ **Contact Person/Title**: _____
Ph #:_____ **Fax #**: _____

Patient Name: _____ **Age**: _____ **DOB**: _____/_____/_____

SSN: _____-____-_____ ☐ Male ☐ Female ☐ Trans M to F ☐ Trans F to M

Address:_____ **County**: _____**Ph #**:_____

Insurance: _____**Policy #:** _____

Policy Holder: _____

Guardian Name: _____ **Ph #**:_____ **Patient Relationship:**_____

CPS / APS Involvement: ☐ YES ☐ NO- If YES, Worker Name & County: _____

Living Arrangements: _____ **Patient able to return:** ☐ YES ☐ NO

Presenting Problem: _____

_____

_____

Suicidal Ideations: ☐ YES ☐ NO **Suicidal Plan:** ☐ YES ☐ NO – If YES, explain: _____

_____

Ever attempted suicide: ☐ YES ☐ NO – If YES, most recent attempt:_____

Homicidal Ideations: ☐ YES ☐ NO **History of Aggression:** ☐ YES ☐ NO

Current Behavior:_____

Legal Charges: ☐ YES ☐ NO **Probation**: ☐ YES ☐ NO – If YES, County: _____

Sexually Inappropriate Behavior: ☐ YES ☐ NO **Sex Offender Status:** ☐ YES ☐ NO

Psychosis: ☐ YES ☐ NO – If YES, explain: _____

_____

Previous Inpatient Psychiatric Care: ☐ YES ☐ NO—If YES, where & when:_____

Mark all as apply: ☐ IDD ☐ Autistic Spectrum ☐ FAS **IQ**:_____

Substance Use: ☐ YES ☐ NO – Drug of choice:_____ Frequency:_____

Date of last use: _____ **Current Withdrawal Symptoms**:_____

Current Medications: _____

Medical Concerns:_____

Completes ADLs Independently: ☐ YES ☐ NO **Wakes up Independently:** ☐ YES ☐ NO

Allergies:_____

History of MRSA: ☐ YES ☐ NO – If YES, last 12 months: ☐ YES ☐ NO

Please fax this referral, all required lab work, and statement of medical clearance to 304-810-2476. If you have any questions or concerns, please contact Orchard Park Hospital Intake at 304-810-2116.