**Outpatient Therapy and Psychiatry Referral Form**

[ ]  **Individual Therapy** [ ]  **Family Therapy** [ ]  **Couples Counseling** [ ]  **Medication Management**

**Today’s Date**: Click here to enter a date.

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| Demographics:  |

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| Name: Click here to enter text. | Age: Age. DOB: enter date. |
| Address: Click here to enter text. | Primary Language: enter text |
| City: City State: State Zip Code: Zip Code | Gender: [ ] Male [ ] Female  |
| Phone: phone number  | Pronouns: Click here to enter text. |
| Email: Click here to enter text. | Ethnicity: Click here to enter text. |
| Race: Click here to enter text. |  |

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| Insurance Information:  |

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| Primary Insurance: Click here to enter text.ID Number: Click here to enter text. | Secondary Insurance: Click here to enter text.ID Number: Click here to enter text. |
| Primary insurance card holder: (self/spouse/parent) :Click here to enter text. | Name of card holder if other than self: Click here to enter text. |

For commercial insurance, please attach a copy of the front and back of card.

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| Referral Source (if other than self/parent/guardian):  |

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| Name: Click here to enter text.  | Phone: Click here to enter text. |
| Address: Click here to enter text.  | Email: Click here to enter text. |
| City: City State: State Zip Code: Zip Code | Relationship: Click here to enter text. |

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| Caregiver/Guardian Information (if applicable): |

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| Name: Click here to enter text. Address: Click here to enter text. City: City State: State Zip Code: Zip Code Email: Click here to enter text. Phone: Click here to enter text. Relationship: Click here to enter text. Primary Language: Click here to enter text. | Name: Click here to enter text. Address: Click here to enter text.City: City State: State Zip Code: Zip Code Email: Click here to enter text. Phone: Click here to enter text. Relationship: Click here to enter text. Primary Language: Click here to enter text. |

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| Emergency Contact: |

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| --- | --- |
| Name: Click here to enter text. | Relationship: Click here to enter text. |
| Phone: Click here to enter text. | Email: Click here to enter text. |

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| Medical History: |

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| Primary Care Physician (PCP): Click here to enter text. | PCP Practice Name: Click here to enter text. |
| PCP Address: Click here to enter text. | PCP Phone: Click here to enter text. |
| Medical Diagnosis: Click here to enter text. | Allergies: Click here to enter text. |
| Current Medications: Click here to enter text. |  |

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| Behavioral Health History: |

Behavioral Health Diagnoses: Click here to enter text.

**Most Recent Behavioral Health Providers (Names/Agency/Dates of Service):**

Psychiatry: [ ]  Yes [ ]  No Click here to enter text.

Therapy: [ ]  Yes [ ]  No Click here to enter text.

Other (Please describe): Click here to enter text.

**Recent Hospitalizations**

Hospital/Dates of Admission and Discharge: Click here to enter text.

Hospital/Dates of Admission and Discharge: Click here to enter text.

Hospital/Dates of Admission and Discharge: Click here to enter text.

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| School Information (if applicable): |

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| --- | --- |
| School: Click here to enter text. | Phone number: Click here to enter text. |
| Grade: Click here to enter text. | Email: Click here to enter text. |
| IEP: [ ]  [ ]  Yes [ ]  [ ]  No  | 504 Plan: [ ]  [ ]  Yes [ ]  [ ]  No  |

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| Agency Involvement (if applicable): |

Dept. of Children and Families [ ]  N/A [ ]  Past [ ]  Current Click here to enter text.

Dept. of Mental Health [ ]  N/A [ ]  Past [ ]  Current Click here to enter text.

Dept. of Developmental Disabilities [ ]  N/A [ ]  Past [ ]  Current Click here to enter text.

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| Additional Information: |

Reason you feel this referral would be beneficial: Click here to enter text.

Is there anything else that would be helpful for us to know (preferences, etc.): Click here to enter text.

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| Please list all possible availability: |

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| --- | --- | --- | --- | --- | --- |
|  | Monday | Tuesday | Wednesday | Thursday | Friday |
| Morning | Enter time | Enter Time | Enter Time | Enter Time | Enter Time |
| Afternoon | Enter time | Enter time | Enter time | Enter time | Enter time |
| Evening | Enter time | Enter time | Enter time | Enter time | Enter time |

Is there a preference for in-person or telehealth sessions? [ ]  In-Person [ ]  Telehealth [ ]  No Preference

Are you open to working with an Intern? [ ]  Yes [ ]  No

Please return this form to Outpatient Services, you can leave it at the front desk or mail it to The Edinburg Center at: Outpatient Referrals; 205 Burlington Road, Bedford, 01730, fax it to Outpatient Services at 781-275-7205, or return via email at outpatient@edinburgcenter.org. If you have any questions please email address above or call at 781-761-5171