**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](mailto:outpatient@edinburgcenter.org). If you have any questions please email address above or call at 781-761-5171