PINE REST Christian Mental Health Services

Outpatient Referral Form

Referral Source Information: _____

Person Making Referral: Date: _____

Referral Organization: Phone #: _____

Office Contact Person: Fax #: _____

Patient Information: _____

Patient Name: Date of Birth: _____

Parent/Guardian (if applicable): Phone #: _____

Primary Insurance: Subscriber Name: _____

Patient Referred To: Lakeland Clinic for Psychiatric Consultation

What is the concern you would like addressed: _____

_____

Important Note: The following labs need to be sent to our office prior to the patient being seen: CBC, CMP, UDS, TSH, Vitamin B12, and Vitamin D. If we do not have these labs prior to the appointment date, we will have to reschedule the appointment.

Patient's Release of Information: *I authorize this referral source to share this form with Pine Rest for the purpose of discussing and scheduling my appointment. An additional release of information will be required to discuss treatment.*

Patient signature:_____ Date:_____

Please fax this form to 877-242-6963 or call Central Access at 866-852-4001.
Pine Rest staff will contact the patient within two business days.

For Pine Rest Use Only

Please fax form back to referral source within 72 hours of request.

Referral Status: Appointment Scheduled: _____ Date_____

Clinic: _____Clinician: _____

Patient unable/declined (circle) to schedule: _____

Not scheduled due to: _____

Pine Rest employee completing this form: _____

Rev. 11/2020