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 for: (check one or more boxes below)

- ☐ **Psychotherapy/Counseling** – *Depression, Anxiety, Substance abuse, Insomnia, Behavior change (smoking cessation, healthy eating, etc.), Personality disorder, Relationship issues, Stress management, etc.*
- ☐ **Psychological Testing** – *ADHD, Learning disability, Autism, Brain injury, Dementia, Pre-surgical testing, etc.*
- ☐ **Psychiatry** – *Medication evaluation and/or management*
- ☐ **Substance Abuse** – *Assessment to determine level of care needed (Outpatient, IOP, PHP, Sub-Acute Detox)*

Please explain: _____

Patient's preference for clinician, if any (gender, age)**:** _____

PHQ-9 Score (If available): _____

Patient's Release of Information: *I authorize this referral source to share this form with Pine Rest for the purpose of discussing reasons for my referral and scheduling my appointment.*

Patient signature: _____ Date: _____

☐ Please check box if patient provided verbal consent.

At initial appointment, patient will be asked to sign a release of information allowing discussion of treatment.

Please fax this form to (877) 242-6963, call Central Access at 866-852-4001, or send referrals electronically through* Great Lakes Health Connect*. 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: _____