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PHYSICIAN REFERRAL

PLEASE PRINT OR TYPE

Applicant's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Date of Birth: _____ Male Female

Diagnosis (DSM-5/ ICD-10-CM):

CODE:	DIAGNOSIS:	CURRENT SEVERITY/ SPECIFIER:
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER CONDITIONS THAT MAY BE FOCUS OF CLINICAL ATTENTION:

_____	_____	_____
_____	_____	_____

Additional details such as justification or assessment measures:

Prognosis:

PSYCHIATRIC HISTORY:

PLEASE ATTACH COPIES OF RECENT RECORDS / REPORTS / DISCHARGE SUMMARIES

A. Current Symptoms

- | | | |
|--------------------------------------------------|------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Self Harm | <input type="checkbox"/> Cognitive Issues |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Suicidal Ideation | <input type="checkbox"/> Substance Use/Cravings |
| <input type="checkbox"/> Delusions | <input type="checkbox"/> Mania | <input type="checkbox"/> Somatic Complaints |
| <input type="checkbox"/> Auditory Hallucinations | <input type="checkbox"/> Aggression | <input type="checkbox"/> Intrusive/Persistent Thoughts |
| <input type="checkbox"/> Visual Hallucinations | <input type="checkbox"/> Disturbances in Sleep | <input type="checkbox"/> Other: _____ |

B. Recent Psychosocial Status

- | | | |
|---------------------------------------------------|---------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Employed Full/ Part Time | <input type="checkbox"/> Volunteering | <input type="checkbox"/> Recent Hospitalization(s) |
| <input type="checkbox"/> Student | <input type="checkbox"/> No Activity | <input type="checkbox"/> Other: _____ |

C. Applicant's most recent living situation:

D. Is the applicant able to meet own basic needs? Yes No

(PLEASE DESCRIBE ANY PHYSICAL LIMITATIONS, STAFF INTERVENTIONS, OR SUPPORTIVE SERVICES NEEDED)



B. History of and / or current likelihood of:

- Suicidal behavior CURRENT PAST HISTORY NO HISTORY
- Violent / Assaultive behavior CURRENT PAST HISTORY NO HISTORY
- Self abusive behavior CURRENT PAST HISTORY NO HISTORY
- Drug / Alcohol abuse CURRENT PAST HISTORY NO HISTORY
 - 1. Have there been any legal, family, or medical problems as a result of substance abuse? YES NO
 - 2. Has substance use complicated psychiatric treatment? YES NO

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

C. Past psychiatric treatment (including medications) and response:

MEDICAL HISTORY:

PLEASE ATTACH COPIES OF RECENT RECORDS / REPORTS

A. Medical & physical illness history (including any surgeries or physical trauma):

B. Current physical illnesses:

C. Any physical limitations / restrictions? YES NO

DESCRIBE:



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Current Medications:

Table with 5 columns: MEDICATION, DOSE, ROUTE, SCHEDULE, HOW LONG? and 8 rows.

Any PRN medications and for what target symptoms:

Table with 5 columns: MEDICATION, DOSE, ROUTE, FREQUENCY, PURPOSE and 5 rows.

Allergies & Reactions: _____

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Signature: _____ Date: _____

NAMES OF OTHER SUPPORTING PROFESSIONALS:

Name: _____ Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

THE APPLICANT MUST BE AT LEAST 18 YEARS OLD. ROSE HILL DOES NOT DISCRIMINATE ON THE BASIS OF RACE, ETHNICITY, NATIONAL ORIGIN, SEX, AGE, RELIGION, CREED, OR SEXUAL ORIENTATION.

