ARCADIAN COUNSELLING & THERAPY

Arcadian Counselling & Therapy Referral Form

Date of Referral: _____

Referring Provider Name _____ Agency _____

Contact Phone # _____

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name _____

Address (incl. zip code) _____

Home Phone # _____ Cell Phone # _____
DOB Sex _____

Insurance Type if applicable: _____

Emergency Contact Name _____ Relationship to Patient _____

Contact # _____

CLINICAL INFORMATION

Reason for Referral _____

_____

Diagnosis (list confirmed if known, if not list suspected) :_____

Former patient in clinic referred to? No Yes, details _____

History of violence and details:_____
History of suicide attempts or self-harm? _____
Dates, means used if applicable:_____
History of psychiatric hospitalizations or detained under Mental health act:
Details _____
Current suicidal / homicidal thoughts? No Yes, details _____
Current outpatient mental health provider? No Yes, details _____ _____
Current Care Plan_____ ___
Additional Information _____
_____

Signature of Referral Source _____

Date / Time _____