Holcomb Behavioral Health Systems
Telepsychiatry Referral

Client's Name: _____ Date of Referral: _____

Date of Birth: _____ SS#: _____

Client's Address: _____

Telephone Number: (Home): _____
(Other): _____

Parent or Legal Guardian: _____ Contact number to schedule: _____

Insurance: ☐ None ☐ CCBH ☐ Medicaid ☐ MA App. Made (date: _____) ☐ Medicare
☐ Private: _____ Policy #: _____ Ins. Phone #: _____

Client Location: ☐ Community ☐ Youth Center ☐ RTF ☐ Inpatient ☐ Prison (re-entry date _____)

Referral Source Name: _____ Relationship: _____

Phone: _____ Email: _____

Reason for referral: _____
_____

☐ Level of Care Determination ☐ Diagnosis ☐ Treatment Recommendations ☐ Medications

Report(s) sent to: ☐ Referral Source ☐ other: _____

Does client have a future psychiatric appointment scheduled with a prescriber elsewhere? ☐ No ☐Yes

Name of Provider: _____ Date of scheduled appointment:_____

Current Psychiatric Medications: _____ _____
_____ _____ _____

How many day supply of medication does the client currently have? _____

Will the client arrive in restraints for the appointment? ☐ No ☐ Yes

MH Diagnosis History: ☐ Major Depression ☐ Bipolar Disorder ☐ Anxiety Disorder ☐ Schizophrenia
☐ Conduct Disorder/Defiant Disorder ☐ ADHD ☐ Spectrum Disorder ☐ IDD
☐ Personality Disorder (specify: _____) ☐ Other (specify: _____)

Treatment Provider(s): _____

Substance Use History: ☐ N/A ☐ Alcohol ☐ Marijuana ☐ Cocaine ☐ Opioids
☐ Amphetamines ☐ Hallucinogens ☐ Prescription medication (specify: _____)
☐ Other (specify: _____)

☐ Abuse history ☐ Dependency history

Treatment Provider(s): _____

Referrals should be faxed to 610-363-8273 <u>or</u> called in to 800-258-8860
Attention: Rachel Barnes
Please include discharge paperwork. ☐ Attached

Revised: 06/14