Greater Lowell Psychiatric AssociatesReferralForm

73 Princeton St. Suite 203
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(P) (978)256-6579
(F) (978)256-1943

Date of Referral: ____________

Referring Provider ________________________ Agency ______________

Contact Phone # _______________

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name ____

Address (incl. zip code) ____

Home Phone # ______________________ Cell Phone # ______________________ Social Security # _____________

DOB __/__/____ Sex ________ Race _______________ Marital Status Single Married Divorced Widowed

Insurance Type:____ Memeber id # ____________________________

Emergency Contact Name ____________________ Relationship to Patient ____________ Contact # ____________

Primary Care Physician _______________________ Clinic Name ______________________ Phone ______________

Metal in the head? No Yes Explain____

CLINICAL INFORMATION

Reason for Referral ____

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Diagnosis (*list confirmed if known, if not list suspected*)

Primary Psychiatric Diagnosis ____

Secondary Psychiatric Diagnoses (including substance abuse) ____

Relevant Medical Diagnoses____

Relevant Social Factors ____

Past Psychiatric History (hx) and Treatment (*please check appropriately*)

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

Hx of violence? No Yes, details ____

Hx of suicide attempts?No Yes, details ____

Hx of psychiatric hospitalizations? No Yes, details ____

Previous symptoms and diagnoses ____

Current Psychiatric Treatment & History

Current Symptoms ____

Current suicidal / homicidal thoughts?No, Yes, details ____

Does patient have a current outpatient mental health provider? No Yes, details _________________________

Additional Information ____

____

Current Medications : Medical and Psychiatric (*name & dose*, attach list if preferred)

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Signature of Referral Source ____ Date ___________________

Fax this completed form with any attachments to (978)256-1943