GREATER LOWELL PSYCHIATRIC ASSOCIATES, LLC 73 PRINCETON STREET SUITE 203 NORTH CHELMSFORD, MA 01863
PHONE: 978-256-6579 FAX:978-256-1943

GREATER LOWELL PSYCHIATRIC ASSOCIATES REFERRAL FORM

Date: _____ Referring provider: _____

Agency: _____ Phone number: _____

PATIENT DEMOGRAPHIC INFORMATION

Name of patient: _____ Date of birth: _____

Home address: _____

Street address

_____

City State Zip code

Home phone: _____ Cell phone: _____

Social Security Number: _____ Gender: ☐M ☐F ☐Other _____ Race: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Lives with Significant Other ☐ Widowed

Health insurance: _____ Member ID number: _____

Emergency contact: _____ Relationship to patient: _____ Phone number: _____

Primary care physician: _____ Clinic: _____ Phone number: _____

CLINICAL INFORMATION

Reason for referral: _____

_____

Current Presentation

Primary psychiatric diagnosis: _____

Secondary psychiatric diagnoses (including substance abuse): _____

Relevant medical diagnoses: _____ Metal in patient's head? ☐ No ☐ Yes: _____

Current symptoms: _____

_____

Relevant social factors: _____

Current suicidal or homicidal thoughts? ☐ No ☐ Yes: _____

Current mental health provider? ☐ No ☐ Yes: _____

Current medications (*please list name and dose, or attach a list*): _____

_____

Psychiatric History

Former patient of GLPA? ☐ No ☐ Yes History of violence? ☐ No ☐ Yes: _____

History of suicide attempts? ☐ No ☐ Yes: _____

History of psychiatric hospitalizations? ☐ No ☐ Yes: _____

Previous symptoms and diagnoses: _____

Additional information: _____

Signature of referral source: _____ Date: _____

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