Yleis Engerman, LADCI, LMHC

My Self Oath Inc., Referral Form

Date of Referral: _____

Referral Source

Referring Provider Name _____ Agency _____ Contact Phone # _____

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name _____ Medical Record Number (if applicable) _____
Address (incl. zip code) _____
Client Email _____ Cell Phone # _____ Social Security # _____
DOB __/__/____ Sex _____ Race _____ Marital Status □ Single □ Married □ Divorced □ Widowed
Medical Ins. # _____ Ins. Name_____ Secondary Ins. _____
Emergency Contact Name _____ Relationship to Patient _____ Contact # _____
Primary Care Physician _____ Clinic Name _____ Phone _____
Current Type of Housing (e.g., group home): _____ Veteran □Yes □No
Potential Transportation Issues? □No □Yes Explain_____

CLINICAL INFORMATION

Reason for Referral _____
_____

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)

Hx of Trauma □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 _____
Does patient have a current outpatient mental health provider? □No □Yes, details _____
Reason not returning _____

Additional Information _____

_____

Current Psychiatric Medications (name & dose, attach list if preferred)

_____

_____

Signature of Referral Source _____ Date /Time _____