FOR CBH OFFICE USE ONLY:

Crisis: Y / N PMHx:_____ Coming from INPT Y / N

NEW REFERRAL SHEET

PATIENT TO COMPLETE:

PATIENT INFORMATION:

Today's Date: _____

Referred By:_____
(Doctor/Therapist/Hospital/Self)

Last Name:_____ First Name:_____

Address:_____

City & State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Gender: Male_____ Female:_____ DOB:_____

Email Address: _____@ Gmail/ @yahoo/ @outlook /@icloud/@_____.com

INSURANCE INFORMATION:

(POLICY NAME)

° **Primary** ° **Self** ° **Spouse** ° **Child**

- ❑ **AETNA**_____
- ❑ **BCBS** _____
- ❑ **CIGNA** _____
- ❑ **CIGNA BEHAVIORAL HEALTH**_____
- ❑ **UHC**_____
- ❑ **MEDICARE**_____
- ❑ **OTHER**_____

Subscriber Name:_____ Group #:_____

DOB: _____Mental Health Phone #:_____

_____

For CBH Office Use Only:

COMPLETED BY: _____ TESTING:_____

INSURANCE BENEFITS:_____ APPT CONFIRMATION S/R:_____

INTAKE PACKET:_____ IOP PACKET:_____ EMAIL SENT: _____

SOQ: Significant Other Questionnaire:_____ UDS _____

For CBH Office Use:

PROV: BAJWA /MIAH/MOHR

DATE:_____

@ _____

For CBH Office Use Only:
Crisis: Y / N PMHx:_____ Coming from INPT Y / N

REASON FOR VISIT:

PATIENT TO COMPLETE

IOP Referral: NO / YES_____

Complaint:_____

All Medications: _____Med. Mgmt.: Yes No

Current Med. Mgmt. Prescriber:_____ Current Therapist:_____

Rx Phone #:_____

Previous Provider/Location:_____

Reason for Changing Provider:_____

Therapist (past/present):_____

Duration of *Depression*:_____ Frequency: _____

Suicide Thoughts: _____ Suicide History: _____

Duration of *Anxiety*: _____ Frequency: _____Weeks/Months/Year
(Years? Months?)

Panic Attacks: _____ Phobias:_____

Duration of *Bipolar*: _____ Hospitalizations: NO / YES; where_____
(Years? Months)

Hospitalizations/Emergency Room Visits: NO / YES; where_____

_____length

Legal History: NO / YES: explain:_____

Psychiatric/ADHD Testing: _____ Medication Trials: _____

Current *Substance Abuse*: _____ Frequency: _____

Previous Detoxification: _____ Residential Treatment: _____

AA Meetings: _____ Legal Issues: _____