



A TRADITION of CARING

1153 Centre Street
Boston, MA 02130

REFERRAL SOURCE

Name

Agency

()

Phone

Date of Referral

CLIENT INFORMATION

Name

Age

DOB

Address

City

State

ZIP

()

Home Telephone

Social Security Number

Marital Status

Ethnicity

Religion

INSURANCE INFORMATION

Insurance Type

()

Insurance Company Telephone Contact

Card Number

Policy Number

Secondary Insurance Policy Number

Authorization Number

Amount of Time Authorized

CARE PROVIDERS

Primary Care Physician

()

Primary Physician's Telephone Number

Therapist

()

Therapist's Telephone Number

Psychiatrist

()

Psychiatrist's Telephone Number

CURRENT MEDICATIONS

Name of Medication Dose Frequency

Name of Medication Dose Frequency

Name of Medication Dose Frequency

Name of Medication Dose Frequency

ALLERGIES

DIAGNOSIS (Please include substance abuse)

Axis I

Axis II

Axis III

Axis IV

Axis V

HISTORY OF PRESENTING ILLNESS

PAST PSYCHIATRIC HISTORY

CURRENT MENTAL STATUS

RISK FACTORS (please check and then briefly describe items checked)

- Substance abuse, Violent behavior, Homicidal ideation, Trauma, Med noncompliance, Suicidality/self-harming behavior

Please fax this form to Christi Barney, RN, MSNCS, at (617) 983-7455.