Tidal Mental Health
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www.tidalmentalhealth.com

PSYCHIATRIC CONSULTATION REFERRAL FORM

If you are a care provider looking to refer a patient/client for psychiatric consultation, please complete this form and attach intake, progress notes, and/or detailed treatment summary. If you are this client's primary care provider, please include documentation of the client's last physical and lab results. Once this information is received, and the client has initiated an appointment request via www.tidalmentalhealth.com, an initial psychiatric consultation can be scheduled.

Name of Client _____ Date of Referral_____

Client's phone _____ Date of Birth_____

Relevant Insurance Information: _____

Name of Referral Source: _____ Name of Practice/Facility_____

Relationship to Referred Client_____

Referral Source phone number _____ Referral Source fax number _____

How did you hear about Tidal Mental Health? _____

Specific reason for Referral: _____

Please list any psychiatric diagnoses: _____

Please list any past/present medical diagnoses: _____

Please list the client's current medications: _____

Does this client have a history of substance abuse? _____

Does this client have any legal issues? _____

Please attach your initial consultation note, recent progress notes, and/or attach a detailed treatment summary that includes the following information:

Presenting concern and recent course of treatment. History of mental health symptoms and treatment of significant substance use, eating or weight concerns, past psychiatric consultation, past psychiatric hospitalizations, history of suicide attempts. Social/developmental history. Strengths, coping skills, interests, areas of life that are going well. Physical health and medical history. Summary, initial formulation, and client goals.

Please fax this form with any attachments to **(781)-261-9633**. Thank you!