CONNECTICUT CENTER
FOR PSYCHIATRIC WELLNESS

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www.CTCtenterForPsychWellness.com

REFERRAL FOR PSYCHIATRIC EVALUATION & TREATMENT

PATIENT DEMOGRAPHICS

Today's Date:	Referring Physician:		Referring Physician Phone Number: ( )
Patient's Name:		Sex at Birth: ❑ M ❑ F	Patient's Cell Phone Number: ( )
Patient's DOB:	Patient's SSN:	Has Pt Been Referred for Mental Health Prior? If so and known, where? ❑ Y ❑ N ❑ Unk	
Primary Insurance:		Patient is a Minor. If Yes, indicate parent/guardian name and contact: ❑ Y ❑ N	

Areas of Concern(s) to be Addressed (Check all that apply):

- ❑ADD/ADHD
- ❑Anxiety/Depression including Postpartum
- ❑Eating Disorder
- ❑Bipolar Disorder
- ❑Insomnia/Sleep Disorder
- ❑LGBTQIA+ Related Concerns
- ❑Stress
- ❑Trauma/PTSD
- ❑Other Neuroses/Psychoses
- ❑Other:

Relevant Risk(s) to be Considered, if Known:

- ❑Hx of violence towards self or others
- ❑Hx of suicidal tendencies
- ❑Hx of sexual abuse
- ❑Hx of anxiety/depression
- ❑Hx of ADD, OCD, bipolar disorder, schizophrenia
- ❑Hx of ETOH, Rx, Illegal drug abuse
- ❑Family Hx of ETOH, Rx, Illegal drug abuse
- ❑Fam Hx of relevant psychological illness(es)
- ❑Relevant criminal Hx/registered sex offender
- ❑Under Dept. of Corrections Supervision
- ❑Other:

PATIENT MEDICAL HISTORY

Primary Psychiatric Dx (If Known):
Secondary Psychiatric Dx (If Known), Including Substance Abuse:
Relevant Medical Dx(es):
Current Psychiatric Medication(s):

Please Fax (**860-331-8044** HIPAA Secure) this referral with the following documentation:

- Your last two office visit notes dated within the previous six (6) months
- Recent diagnostic imaging reports (X-Ray, CT Scan, MRI, etc.)
- Blood work lab results within the past six months (CBC/A1C/BUN/Creat/Ast/Alt/Bili)

Referring Physician X:_____ Date:_____