Sea Glass Psychiatry
COMPASSIONATE CARE. CLEAR MIND. STRONGER YOU.

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REFERRAL FOR PSYCHIATRIC EVALUATION & TREATMENT

PATIENT DEMOGRAPHICS

Today's Date:	Referring Provider (MD, NP, MSW, LCSW, etc.):	Referring Provider's 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 (**800-859-7958** HIPAA Secure) or scan/email this referral (office@seaglassct.com) with office notes, or any other documentation you'd like us to have.

- *Note that while we'd be happy to respect your office policies related to PHI releases, under federal HIPAA regulations (§45 CFR 164.506), co-treating providers do not need a signed ROI to share protected health information. The HIPAA Privacy Rule permits providers to share medical records, diagnoses, and treatment details to coordinate care for a shared patient under the umbrella of "Treatment, Payment, and Health Care Operations".*

Referring Provider X:_____ Date:_____