THUNDERMIST BEHAVIORAL HEALTH REFERRAL FORM
PATIENT INFORMATION

Patient Name	Date of Birth	Gender

Parent/Guardian Name	Preferred phone number

Home Address

City, State, Zip

Health Insurance	Policy Number

Primary Care Physician	Phone Number

REFERRAL INFORMATION

Date of Referral	Referring Provider (if not PCP)

Reason for Referral/Clinical Question and brief history of concern

Current Problem List

Current Medications

Current Behavioral Health Treatment (if any)

Confidentiality Concerns ___Y ___N	Safety Concerns ___Y ___N

Primary goals for initial psychiatric visit	
Parents:	Child:

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RELEVANT HISTORIES

PSYCHIATRIC
Prior Diagnoses/Problems
Prior Outpatient Treatment
Prior Inpatient/Partial/Residential Treatment
Previous Medication Trials
Previous Testing/Evaluations

History of suicidality?	History of non-suicidal self-injury?
Y/N Specify:	Y/N Specify:

EDUCATIONAL/VOCATIONAL			
School	Grade	IEP	504 Plan
		___Y ___N	___Y ___N

Special Ed Services	School refusal or truancy?
	Y/N Specify:
Change in academic performance?	Employment (if any)
Y/N Specify:	

SUBSTANCE USE
Tobacco/nicotine:
Alcohol:
Marijuana:
Other substances:

LEGAL	
Court or other legal involvement?	DCYF involvement?
Y/N Specify:	Y/N Specify

ADDITIONAL INFORMATION	
Available external documents	Other