OPTIONS FOR INDEPENDENCE
8326 Main St. Building 3 * Houma, LA 70363
985-868-2620 / 985-868-8547 (Fax)

Psychiatry Referral Form

Date of Referral: _____ Referral Source: _____

Name: _____ SSN#: _____

Gender: _____ Age: _____ DOB: _____

Parent's Name: _____

Address: _____

City: _____ Zip: _____ Parish: _____

Phone #: _____ Cell #:_____ Other #:_____

Medicaid: ☐Yes ☐No #_____

Diagnosis Code: _____

Current Mental Health Services: ☐No ☐Yes – Agency_____

			Comments:
Previously evaluated by a psychiatrist	☐No	☐Yes	
Did you have difficulty finding psychiatry services?	☐No	☐Yes	
Currently taking any mental/behavioral health medications?	☐No	☐Yes	
Past history of taking mental / behavioral health medication?	☐No	☐Yes	
Substance Use Issues?	☐No	☐Yes	
Legal / FINS Issues?	☐No	☐Yes	

Comments – Reason for Referral

(Need to include <u>specific</u> symptoms, behaviors, presenting issues)

Consent Forms must be attached for: ☐PCP/Pediatrician ☐School ☐Current & Past MH Providers
(to include hospitals, inpatient)

For Office Use Only: Scheduled Appointment Date: _____