The BUISE Foundation Referral Form

Date of Referral:_____ Referral Source:_____
New Client: Yes or No Returning Client: Yes or No

Name:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Best Contact Number:_____ Email Address:_____
Date of Birth:____/____/_____ Age:_____ Race:_____

Insurance Type/Number:_____ Self Pay: Yes or No

Emergency Contact:_____ Relationship:_____ Contact:_____
PCP:_____ Clinic Name:_____ Contact:_____

CLINICAL INFORMATON:
Reason for Referral:_____
_____

Previous MH Provider, if so where:_____
Reason for leaving:_____
Previous diagnosis given:_____
Relevant Medical/Psychiatric Concerns:_____

Previous hx of suicidal attempts, if so please explain:_____
Previous hx of psychiatric hospitalizations:_____ When?_____ How Long?_____
Where?_____
Previous hx of violence, if so please explain:_____

Current suicidal/homicidal thoughts, if so please explain:_____
Current Medications:_____

Signature of Referral Source_____ Date:_____

OFFICE USE ONLY:
APPROVED:_____ DENIED:_____
STAFF INITIALS:_____