HEWITT
PSYCHIATRIC CARE
Compassionate Care. Lasting Hope.

NEW PATIENT

PSYCHIATRIC REFERRAL FORM

Michelle Hewitt, NP | Marion, Indiana

PATIENT INFORMATION

Patient name | **Date of birth** | **Age** | **Sex**

Phone | **Email** | **Preferred contact**

☐ Phone ☐ Text ☐ Email

Parent / guardian (if minor) | **Guardian phone** | **Relationship**

Insurance | **Member ID** | **Payment**

☐ Self-pay

Primary care provider | **PCP phone / practice**

Preferred pharmacy (name / location)

REFERRING PROVIDER / REQUEST

Referring provider / clinician | **Credentials** | **Practice**

Phone | **Fax** | **Email** | **Referral date**

Urgency

☐ Routine ☐ Soon ☐ Urgent

Requested service

☐ Diagnostic evaluation ☐ Medication management ☐ Consultation

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REFERRAL DETAILS

Primary concern

- ☐ Depression
- ☐ Anxiety
- ☐ ADHD
- ☐ Mood / bipolar
- ☐ OCD
- ☐ Trauma / PTSD
- ☐ Psychosis
- ☐ Sleep
- ☐ Behavioral concerns
- ☐ Diagnostic clarification
- ☐ Other

Other concern (specify)

Specific question / goal for referral

Complete all pages and return via secure fax or another approved secure method.

CLINICAL HISTORY

Known / prior psychiatric diagnoses

Current psychiatric medications and doses

Previously tried / failed medications and reason discontinued

Relevant medical conditions / allergies

Current therapist / counselor

Phone

Prior treatment

- ☐ Outpatient
- ☐ IOP / PHP
- ☐ Inpatient
- ☐ Residential
- ☐ None / unknown

Last hospitalization / ED

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ADDITIONAL CLINICAL HISTORY

Substance use concerns

- [ ] None known
- [ ] Alcohol
- [ ] Cannabis
- [ ] Opioids
- [ ] Stimulants
- [ ] Other Substance

Pregnant / breastfeeding (if applicable)

- [ ] No
- [ ] Yes
- [ ] Unknown

Legal / court-related referral

- [ ] No
- [ ] Yes

SAFETY / ACUITY

Current safety concerns

- [ ] None known
- [ ] Suicidal ideation
- [ ] Self-harm
- [ ] Homicidal ideation
- [ ] Psychosis
- [ ] Aggression

History of suicide attempt / self-harm (details)

Approximate date

History of violence / aggression (details)

RECORDS INCLUDED

Records enclosed

- [ ] Medication list
- [ ] Recent labs
- [ ] Psychiatric records
- [ ] Hospital / discharge
- [ ] Testing / evaluations
- [ ] Therapy summary
- [ ] Other

Additional information / other records

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FOR OFFICE USE ONLY

Date received

Reviewed by

Disposition

- ☐ Appropriate for intake
- ☐ Higher level of care recommended
- ☐ Insurance / financial issue
- ☐ Need additional information / records
- ☐ Outside practice scope
- ☐ Unable to contact

Patient / guardian contacted (date)

Outcome

Scheduled appointment date

Declined / other details

REFERRAL INSTRUCTIONS

Return this form and relevant records by secure fax or another approved secure method.

Submission does not guarantee acceptance; the practice will contact the patient / guardian.

IMPORTANT SAFETY NOTICE

This form is not monitored for emergencies and is not an emergency referral pathway.

For immediate safety concerns, use appropriate emergency or crisis services.