Special Medical Services

&

Bureau of Developmental Services

PSYCHIATRY REFERRAL FORM FOR CONTRACTED SERVICES

Date of Referral ______________________

Client Name ______________________ Date of Birth ______________

Address ____

City ______________ State ______ Zip ______

☐ Guardian ☐ Parent Name ______________________ Phone ______________

Guardian papers are included with the SMS/BDS referral ~ ☐ Yes ☐ No ☐ Not applicable

Address ____

(if different than the above listed for client)

Contact person for scheduling an appointment ______________________

Relationship to client ______________________ Phone ______________

☐ Coordinator who made referral Name of: ______________________

☐ Area Agency Name of: ______________________ ______________

Address ______________________ Phone ______________

☐ Psychiatrist Name of: ______________________

Address ______________________ Phone ______________

PCP Name ______________________ Phone ______________

Address of PCP

Medications

Current Medications : ____

____

List all Past Psychiatric Medications or Trials:

____

Reason for Referral

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