REFERRAL FOR PSYCHOLOGICAL SERVICES

CLIENT NAME: ____ DATE: ______________

FACILITY: ___________________________ ROOM NUMBER: __________

CURRENT LEVEL OF CARE: ___ Skilled ____ Long Term Care ___ Assisted _____ Independent

REASON(S) FOR REFERRAL:

	Anxiety or worry, fearful		Hx mental health treatment		Refusing medical or nursing care
	Family or relationship problems		Receiving psychotropic medication		Resisting or refusing PT, OT, ST
	Appears or expresses sadness		Refusing medications		Difficulty performing self-care within abilities
	Isolated or withdrawn		Recent loss, death of someone close		Manipulative behavior
	Loss of interest in most things		Forgetful and/or confused		Frequent negative statements
	Change in appetite, weight change		Alcohol or drug issues		Passive death wishes
	Tearful or crying frequently		Physically aggressive		History of suicidal ideation
	Difficulty concentrating		Verbally aggressive		**CURRENT SUICIDAL STATMENTS**
	Elevated mood, excessive talking		Sexually inappropriate behavior		Hallucinations or delusions
	Difficulty adjusting to health condition(s)		Irritable, Argumentative or highly demanding		Chronic pain, high use of pain meds

Other information:____

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Name of contact person for additional information: ________________________________

Name of referring physician: ____

Responsible party/P.O.A. has been notified of referral? YES______ NO______

If NO, explain here: ____

SIGNATURE AND TITLE of facility staff member completing this form:

____

(SIGNATURE) (TITLE)

This form should be placed in the patient chart with the signed authorization for billing/evaluation and a signed physician's order.