



REFLECTIONS HEALTH & WELLNESS

Lewis & Evans, LLC
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REFERRAL FOR PSYCHOLOGICAL SERVICES

CLIENT NAME: _____ DATE: _____

FACILITY: _____ ROOM NUMBER: _____

CURRENT LEVEL OF CARE (check all that apply): _____ Skilled/Part A _____ Long-Term Care
 _____ Assisted _____ Independent _____ Hospice

REASON(S) FOR REFERRAL (check all that apply):

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Isolated or withdrawn	Recent loss, death of someone close	Harmful/Dysfunctional behavior
Loss of interest in most things	Forgetful and/or confused	Frequent negative statements
Change in appetite, weight change	Alcohol or substance abuse 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: _____

Name of contact person for additional information: _____

Name of referring physician: _____

Responsible party/P.O.A. has been notified of referral? YES _____ NO _____ (briefly explain): _____

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.