Psychiatric Referral Application

Date of Application ____________________

Referring Provider: ____________________ Referring Provider's Phone Number: ____________________

Previously seen by: ☐Dr. M. Brummer ☐Dr. J. Brummer ☐Dr. Bingham ☐Dr. Heischmidt ☐Dr. Crowell ☐Dr. Bierman

Patient's Name: ____________________

DOB: ____________________ Gender: ________

Race: ☐White ☐Asian ☐Native Hawaiian ☐African American ☐Hispanic

☐American Indian or Alaskan Native ☐Other Pacific Islander Other Race

Ethnicity: ☐Hispanic ☐Non Hispanic Translator Needed? ☐Yes ☐No

○ **Guarantor's Full Name:** ____________________ Gender: ________ DOB: ____________
(Responsible Party) LAST FIRST MIDDLE Transgender ☐

Previous/Maiden Name: ____________________ ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Address: ____________________ City: ____________ St.: ________ Zip: ________

Home Ph: ____________ Cell Ph: ____________ Email: ____________________

Social Security No.: ____________________ Driver's License No.: ____________________

Employer: ____________________ Phone No.: ____________ Ext.: ________

Address: ____________________ City: ____________ St.: ________ Zip: ________

Occupation: ____________________

○ **Spouse/Partner Full Name:** ____________________ Gender: ________ DOB: ____________
LAST FIRST MIDDLE Transgender ☐

Legal Guardian(s) ____________________ **Relationship** ____________________
(If patient is a minor) LAST FIRST MIDDLE

Phone No.: ____________________ DOB: ____________

In case of emergency, contact (Other than spouse): ____________________

Address: ____________________ City: ____________ St.: ________ Zip: ________

Relationship: ____________________ Phone No.: ____________ Ext: ________

Current Primary Care Provider:

Referring Provider Signature: ____________________

Please provide a front and back copy of **ALL** insurance cards, including Medicare and/or Medicaid along with a current copy of the patient's driver's licenses or other photo ID

Family Care Associates

Referral Application

List of current medications
(including over-the-counter):
____
____
____
____
____
____
____
____

Please list any additional medications you have taken in the last 12 months
(including over-the-counter):
____
____
____
____
____
____
____

Medication Allergies:
____
____
____

Side Effect/Reaction:
____
____
____

Health problems:

Current:
____
____
____
____

Past:
____
____
____

List of any hospitalizations, surgeries or injuries
(please include dates):

Condition: Date:
____
____
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