



**CONNECTICUT CENTER
FOR PSYCHIATRIC WELLNESS**

136 Sherman Avenue – Lower Level Suite #6 • New Haven, Connecticut 06511
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www.CTCenterForPsychWellness.com

REFERRAL FOR PSYCHIATRIC EVALUATION & TREATMENT

PATIENT DEMOGRAPHICS	Today's Date:	Referring Provider (MD, NP, MSW, LCSW, etc.):	Referring Provider's Phone Number: ()
	Patient's Name:	Sex at Birth: ☐ M ☐ F	Patient's Cell Phone Number: ()
	Patient's DOB:	Patient's SSN:	Has Pt Been Referred for Mental Health Prior? If so and known, where? ☐ Y ☐ N ☐ Unk
	Primary Insurance:	Patient is a Minor. If Yes, indicate parent/guardian name and contact: ☐ Y ☐ N	

Areas of Concern(s) to be Addressed (Check all that apply): ☐ ADD/ADHD ☐ Anxiety/Depression including Postpartum ☐ Eating Disorder ☐ Bipolar Disorder ☐ Insomnia/Sleep Disorder ☐ LGBTQIA+ Related Concerns ☐ Stress ☐ Trauma/PTSD ☐ Other Neuroses/Psychoses ☐ Other:	Relevant Risk(s) to be Considered, if Known: ☐ Hx of violence towards self or others ☐ Hx of suicidal tendencies ☐ Hx of sexual abuse ☐ Hx of anxiety/depression ☐ Hx of ADD, OCD, bipolar disorder, schizophrenia ☐ Hx of ETOH, Rx, Illegal drug abuse ☐ Family Hx of ETOH, Rx, Illegal drug abuse ☐ Fam Hx of relevant psychological illness(es) ☐ Relevant criminal Hx/registered sex offender ☐ Under Dept. of Corrections Supervision ☐ Other:
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PATIENT MEDICAL HISTORY	Primary Psychiatric Dx (If Known):
	Secondary Psychiatric Dx (If Known), Including Substance Abuse:
	Relevant Medical Dx(es):
	Current Psychiatric Medication(s):

Please Fax (800-621-4166 HIPAA Secure) this referral with the following documentation:

- Your last two office visit notes dated within the previous six (6) months
- Recent diagnostic imaging reports (X-Ray, CT Scan, MRI, etc.)
- Blood work lab results within the past six months (CBC/A1C/BUN/Creat/Ast/Alt/Bili)

Referring Provider X: _____ Date: _____