

Referral Phone: 414.266.3339 • Fax: 414.266.3735

Our goal is to work with you to provide the most appropriate and timely services. In order to do this, we ask you to please complete the following to ensure we know how to best serve you and your patient.

Patient Information	Referring Provider Information
Patient Name: _____	Provider Name: _____
Parent/Guardian Name(s): _____	Provider Address: _____
Date of Birth: _____	_____
Home Phone Number: _____	Phone Number: _____
Work Phone Number: _____	Fax Number: _____
Case Worker Name: _____	
Case Worker Phone Number: _____	
Insurance Carrier: _____	<b>NOTE: If child is in foster care, <u>ONLY</u> the caseworker can refer.</b>

**Our center does not provide treatment for alcohol and/or substance abuse. Please have the patient contact their insurance company for available treatment options for these disorders.**

**Please answer these questions:**

1. What is the patient's chief complaint? **Describe** \_\_\_\_\_

Severity of Problem     Mild     Moderate     Severe (been to Emergency Room or out of school)

Describe details \_\_\_\_\_

2. Pertinent past psychiatric/medical history \_\_\_\_\_

3. What is the key question you want addressed? \_\_\_\_\_

<b>What service are you seeking at this clinic? (CHECK ONE).</b>	
<input type="checkbox"/> Evaluation Clinic (diagnosis and treatment recommendations only)*	<input type="checkbox"/> Individual therapy
<input type="checkbox"/> Second Opinion (diagnostic review and/or medication evaluation)*	<input type="checkbox"/> Family therapy
* Patient returned to you for ongoing treatment	
<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Group therapy
<input type="checkbox"/> Neuropsychological Testing	<input type="checkbox"/> Medication Management
<input type="checkbox"/> Other (specify): _____	

**\*\* Please fax this form to 414-266-3735 along with pertinent medical records**

**AUTHORIZATION:** I give the Psychiatry Center permission to contact me at the phone numbers provided to facilitate this referral and to contact my child's referring provider to share information regarding this referral.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**The parent must call our intake line at 414-266-3339 to complete this referral.**

Referring Provider Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

<b>OFFICE USE ONLY</b>	
Date Received: _____	Clinic/Clinician Assigned: _____
<input type="checkbox"/> Referral Accepted	Date and Time of Appointment: _____
<input type="checkbox"/> Referral Denied	Reason: _____
Notes: _____	
_____	
_____	
_____	

APPLY DT BARCODE STICKER  
MD Referral Accepted DT 346  
MD Referral Denied DT 9901