Facility Referral for Psychological Services

Resident ________________________ **Facility**______________**Rm** _________

Reason for referral____

____

Baseline of problem behavior (How often per shift & under what circumstances does behavior occur?) ____

Recent history ____

____

____

Date of Birth ___________________________ **Admission date** __________________________

Social Security Number _____________________ **Level of Care** ☐ **Skilled** ☐ **Nursing** ☐ **AL** ☐ **IL**

Insurance Information

******Please attach <u>current</u> copies (front & back) of insurance cards.******

Primary Insurance ____________________________ **ID Number** ____________________________

Secondary Insurance __________________________ **ID Number** _____________________________

<u>OTHER INSURANCE:</u>

Insurance Company ____

Member ID/ Policy Number _______________________**Group Number**_______________________

Responsible Party __________________________ **Relationship** _____________ **POA:** ☐ **Yes** ☐ **No**

Address ____

City ____ **State** _____________ **Zip** _______________

Home phone __________________ **Work phone** _________________ **Cell/pager**_______________

****Please have patients fill out the necessary <u>consent form</u> that is required before treatment can begin.****

Primary care physician ____________________________ **Physician Order written?** ☐ **Yes** ☐ **No**

Designated staff signature_____________________________________ **Date** ________________

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