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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