Embodied Living Counseling, LLC

Provider Referral Form

Please fax form to (401) 386 - 3443

Referral Source/Referring Provider Name:_______________________ Agency: __________________
Contact Phone #: _____________________________

PATIENT DEMOGRAPHIC INFORMATION

Clients's Name: ____

Address (incl. zip code):

____

Home Phone #: ________________________ Cell Phone #:_____________________________
Social Security #: ______________________ Email: __________________________________

DOB: __/__/____ Gender Identity/Pronouns: ____________________ Race: ______________
Marital Status: □ Single □ Married □ Divorced □ Widowed

Insurance Carrier and Member #:

____

Emergency Contact Name or Guardian: ____
Relationship to Patient: __________________________ Contact #: ________________________

PrimaryCare Physician: __________________________ Clinic Name: ____________________
Phone: _____________________________

CLINICAL INFORMATION

Reason for Referral:

____
____
____
____
____
____
____

Therapy Type:

□ Individual □ EMDR □Family □ Marriage/Couples □ Dance & Movement

Diagnosis (list confirmed if known, if not list suspected):

PrimaryPsychiatric Diagnosis:

____

Secondary Psychiatric Diagnoses (including substance abuse if applicable):

____

Relevant Medical Diagnoses:

____

____

Past Psychiatric History (hx) and Treatment (please circle appropriately)

Hx of violence? No Yes, details ____

____

Hx of current or past suicidal or homicidal thoughts? No Yes, when? ____________________

____

____

Hx of suicide attempts? No Yes, when? ______________________________________

Hx of childhood abuse? No Yes, details ______________________________________

Hx of domestic abuse? No Yes, details ______________________________________

Hx of psychiatric hospitalizations? No Yes, when? Length of stay? ____________________

____

____

____

Hx of substance/alcohol abuse? No Yes, details ________________________________

Hx of past mental health treatment: ____

____

____

Current Psychiatric Medications (name & dose, attach list if preferred):

____

____

____

____

Time frame best for sessions? ____

Session Preference: □ In-Person □ Telehealth

Clinician preference? ______________________________ □ Male □ Female

Signature of Referral Source: ____________________________________ Date: ____________