Providence Psychiatry and Counseling
Providence Medical Group
900 N Orange St, Suite 202
Missoula, MT, 59802
(406) 327-3362

Referral Form

General Information:

Patient Name: _____

DOB: _____

Referring Provider: _____

Diagnosis/concern: _____

☐ Attach Face Sheet: (Must include: Name, DOB, Address, Phone #, Insurance information)

What services are you referring them for?

☐ Psychiatry/Medication (Must include a complete medication history)

☐ Therapy/Counseling

☐ ECT

Records:

1. Include ☐ **Lab results** (from the year) and the patient's ☐ **Entire Medication List**
2. Include records from the last year from any of the following sources: (See ROI attached)

Sources:

☐ **Primary Care**: First & Last Name: _____

Phone # _____ City: _____

☐ **Therapist:** First & Last Name: _____

Phone # _____ City: _____

☐ **Previous Psychiatrist**: First & Last Name: _____

Phone # _____ City: _____

Date Range: _____

☐ **Neuropsych testing**: Location: _____

Date Range: _____

☐ **Hospitalizations**: Location: _____

Date Range: _____