Catalpa Health
Referral Form

Catalpa Health
Mental Health & Wellness For Kids
Affinity Health System · Children's Hospital of Wisconsin · ThedaCare

Referral Phone Number: 920-750-7000 Fax: 920-882-5484
444 N. Westhill Blvd.; Appleton, WI 54914

Thank you for referring your patient to Catalpa Health. Please provide the following information and pertinent clinical information so that we can provide the best and most timely service.

Patient Information	**Referring Provider Information**
Patient Name: _____	Provider Name: _____
Parent/Guardian Name(s): _____	Provider Address: _____
Patient Address: _____	_____
Date of Birth: _____	Phone Number: _____
Phone Number: _____	Fax Number: _____
Insurance: _____	

Our center does not provide treatment for alcohol &/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?

   _____
   _____
   _____

   Frequency of Problem: _____
   Severity of Problem: ☐ Mild ☐ Moderate ☐ Severe (been to ER or out of school)
   Describe Details:

   _____
   _____

2. Mental Health History (*Previous counseling, psychological testing, psychiatric care/medication*):

   _____
   _____
   _____

3. Medical History: _____

<u>REFERRING PATIENT FOR (Please note: Catalpa Health may not offer all services requested. Patient may be referred to or offered another provider/facility for required services)</u> :

☐ Initial Evaluation/Counseling ☐ Psychological Testing ☐ Neuropsychological Testing

☐ Medication Management (*the following criteria are recommended*):

- Past or current evaluation/diagnosis/treatment by therapist, psychologist or psychiatrist
- Current medication management by physician or psychiatrist

****Please fax this form to the Call Center at (920) 882-5484. The most recent office visit note, therapy progress note or psychological evaluation would be appreciated as well.**

<u>The parent &/or guardian MUST call the intake line at 920-750-7000 to complete this referral as we need demographic and insurance information to schedule an appointment</u>.**

Referring Provider Signature:_____ Date/Time: _____