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**Catalpa Health Referral Form**

Referral Phone Number: (920) 750-7000, Fax Number: (920) 882-5484

**Thank you for your referral to Catalpa Health!**

**Please provide the following information and pertinent clinical documents**

**so that we can provide the best and most timely service!**

**Catalpa Health staff will perform an intake assessment and based on your referral and the family’s input, will match the patient with appropriate services. Patient may be referred to or offered another provider/agency, if this is deemed to be in their best interest.**

**If your patient has not been contacted within 1 week of referral, please have them call us directly!**

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

**Catalpa Health does not provide treatment for alcohol and/or substance abuse.**

Please complete the following information in its entirety:

1. Please list most concerning mental and behavioral health symptoms:

2. Please list past/current mental health diagnoses:

3. Please list name and agency of current counselor, if applicable:

4. I am referring the patient for the following services:

[ ]  Mental Health Counseling (short-term or long-term individual/group/family psychotherapy)

[ ]  Psychiatry (psychotropic medication management beyond scope of primary medical provider)

**\*Current medication list is required for all psychiatry referrals**

[ ]  ADHD Evaluation (assessment by licensed counselor for ADHD diagnosis when no other complex concerns are present)

[ ]  Psychological Evaluation (extensive mental health diagnostic assessment for patients with mental health concerns that are complex, unresponsive to treatment, or have neuropsychological origin)

**\*Approval from psychology staff and insurance provider is required prior to evaluation**

5. Is the patient’s parent/guardian aware and in agreement with referrals for the services checked above? [ ]  Yes [ ]  No- Explain:

 6. Have you included any previous psychological evaluations or other relevant mental health history records? [ ]  Yes [ ]  No **\*Other types of medical records are not needed to complete your referral**