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Psychotherapist Referral Form for Psychopharmacology

Instructions:
If you would like to make a referral of a current client for psychopharmacology services, please complete the following form and fax (781-551-3396) it or mail it to me. Please note that this referral form is also available online at our website: www.cfpsych.org. Click on "*About Us*" and then click on "*Kathy Andolina*", then, "*Psychotherapist Referral Form*"

Instructions for Your Clients: Please instruct your client to contact our office to complete an intake. This is an essential first step. However, the fastest and easiest way to complete this first step is to go online at www.cfpsych.org and click on "*Getting Help*" and then on "*Online Intake*". Remember, if they choose to not use the online intake process, they must call and speak with one of our receptionists (781-551-0999, x201) to complete this first step. Even after they have completed the intake we must check benefits, set them up in our system, contact them to schedule an appointment and mail out registration information that they will bring to their first appointment. We typically are able to respond within 4-5 business days, if not sooner. **Please encourage your clients to initiate this process as soon as possible.**

Patient Name ____ **DOB**: ______________________

Location to be seen:
___ Holliston Office (Tuesdays only) ____Norwood Office (Fridays only)
___ Either/First Available

Therapeutic Issues:

Are there any limitations/complications I should know about? (Check all that apply)

____ Low insight

____ Highly anxious about medication

____ Poor Psychosocial Supports

____ Legal Issues (specify)

____ Learning Disabilities: (specify)

____ Child will not cooperate with treatment

____ Trauma/Dissociation

____ Ongoing Medical Issues:

____ Non-Supportive Spouse

____ Non-Supportive Parent

____ Highly Somatic

If you have any particular questions or interest in medications for your client please describe:

Has your client had any prior treatment or services? How recently? With whom?

Outpatient Psychotherapy ________________________ Marital Counseling ________________________

School Based Counseling ________________________ IEP/CORE Eval __________________________

Psychological Testing ___________________________ Group Counseling ________________________

Family Counseling _____________________________ Day treatment / Partial Hospital ____________

Other: ____

Do you anticipate that your client will require additional service referrals in the near future (i.e. group therapy, AA/NA, partial or inpatient level of care, psychological or neuropsych testing, etc ?)

How would you prefer that I be in contact with you? (Indicate your preferred method)

Email: ____

Tel: ____

Pager: ____

Voice Mail: ____

Faxed Communications: __________________________________

7. Is there anything else you would like me to know in order to work effectively with you or your client?

Thank you! I look forward to working with you and your client soon!

Please fax back this form to 781-551-3396

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