POINSETT PSYCHIATRIC INNOVATIONS, PA

414 Pettigru St., Suite C ▪ Greenville, SC 29601 ▪ Phone: 864.412.0800 ▪ Fax: 864.438.4744

Physician Referral Form for New Patient Evaluation/Intake for Psychiatry AND Addiction

Please Note: ***Our practice does not participate in any insurance plan including Medicare and Medicaid****. Patients are required to pay for services at each appointment.*

Directions for Completion:

1. Please complete this form.
2. Attach requested additional information.
3. Please have your staff call 864.412.0800 to let us know you will be faxing a patient referral.
4. Fax all information to 864.438.4744.

Referring Physician Name: _____ Date: _____

Physician Address: _____

Physician telephone number: _____ Fax: _____

Patient name: _____ Date of Birth: _____

Patient Address: _____

Patient home telephone: _____ Cell phone: _____

Has the patient be informed that Poinsett Psychiatric Innovations, PA *does not participate in any insurance plan* – including Medicare and Medicare – or accept insurance company reimbursement for services provided? ___ Yes ___ No

In what time frame would you like the patient to be seen for evaluation and intake services?

____ 48 to 72 hours ____ One week _____ Two to three weeks ____ Four to six weeks

What is your desired outcome from the referral?

____ One-time consultation with diagnosis and treatment recommendations

____ Poinsett Psychiatric Innovations, PA to assume treatment of the patient

____ Assist with referrals to subspecialists based on evaluations results

____ Specific addiction treatment

____ Other: _____

Would you like to have telephone contact with Poinsett Psychiatric Innovations, PA prior to the patient being seen for the initial appointment? ___ Yes ___ No

For emergency situations, can Poinsett Psychiatric Innovations, PA contact you directly to discuss the case? ___ Yes ___ No

Reason for Referral: (please check all that apply)

____Diagnostic clarification
____Treatment recommendations
____Failure of current treatment
____Addictive behaviors
____Sleep disturbance
____Sexual dysfunction
____TMS (Transcranial Magnetic Stimulation)
____New onset psychotic symptoms
____Psychotherapy evaluation and recommendations
____Behavior dangerous to self or others
____Evaluation for treatment of opioid addition
____Evaluation of cognitive dysfunction
____Psychological factors affecting medical condition(s)
____Psychological aspects of chronic pain syndrome
____Evaluation of side-effects of psychotropic medications

Other: _____
_____
_____

Symptoms/Signs: (please check all that apply)

___ Hallucinations
___ Delusions
___ Dysphoric mood
___ Disorganized speech
___ Disorganized behavior
___ Aphasia, apraxia, agnosia
___ Self-mutilation
___ Social isolation
___ Amotivational behaviors
___ Panic attacks
___ Erectile dysfunction
___ Decreased libido
___ Impulse control issues
___ Affective instability/irritability
___ Expansive/euphoric mood
___ Decreased concentration/focus
___ Executive function disturbances
___ Suicidal ideations/suicide attempts
___ Overwhelming grief and/or guilt
___ Flashbacks, nightmares, hyperarousal
___ Ritual behaviors including mental rituals
___ Impulsive and/or risky behavior patterns
___ Initial or middle insomnia
___ Restriction of food intake/exce4ssive dieting
___ Aggressive cognitions and/or homicidal ideations
___ Other: _____

Please attach: ____ Copies of all laboratory and radiological studies ____ Medication list ____ Allergy list
____ Any additional notes or information you feel would assist us in caring for the patient

_____

What happens next: Once all materials have been received, your patient will be contacted by our Clinical Intake Therapist to briefly review case material, describe our services, therapeutic options, financial policies and answer any questions which the patient may have regarding our practice.

Physician Signature: _____ **Date**: _____

Please fax this form AND supporting documentation requested above to 864.438.4744. Thank you.