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Holly, MI 48442-9507
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Physician Referral

PLEASE PRINT OR TYPE

Applicant's Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: ______________

Phone: ______________________ Date of Birth: ______________ ☐ Male ☐ Female

Diagnosis (DSM-5/ ICD-10-CM):

CODE:	DIAGNOSIS:	CURRENT SEVERITY/ SPECIFIER:
________	______________________________	______________________
________	______________________________	______________________
________	______________________________	______________________

OTHER CONDITIONS THAT MAY BE FOCUS OF CLINICAL ATTENTION:

________	______________________________	______________________
________	______________________________	______________________

Additional details such as justification or assessment measures:

Prognosis:

PSYCHIATRIC HISTORY:

PLEASE ATTACH COPIES OF RECENT RECORDS / REPORTS / DISCHARGE SUMMARIES

A. Current Symptoms

- ☐ Anxiety
- ☐ Depression
- ☐ Delusions
- ☐ Auditory Hallucinations
- ☐ Visual Hallucinations
- ☐ Self Harm
- ☐ Suicidal Ideation
- ☐ Mania
- ☐ Aggression
- ☐ Disturbances in Sleep
- ☐ Cognitive Issues
- ☐ Substance Use/Cravings
- ☐ Somatic Complaints
- ☐ Intrusive/Persistent Thoughts
- ☐ Other: ____________________

B. Recent Psychosocial Status

- ☐ Employed Full/ Part Time
- ☐ Student
- ☐ Volunteering
- ☐ No Activity
- ☐ Recent Hospitalization(s)
- ☐ Other: ____________________

C. Applicant's most recent living situation:

D. Is the applicant able to meet own basic needs? ☐ Yes ☐ No

(PLEASE DESCRIBE ANY PHYSICAL LIMITATIONS, STAFF INTERVENTIONS, OR SUPPORTIVE SERVICES NEEDED)

B. History of and / or current likelihood of:

Suicidal behavior	☐ CURRENT	☐ PAST HISTORY	☐ NO HISTORY
Violent / Assaultive behavior	☐ CURRENT	☐ PAST HISTORY	☐ NO HISTORY
Self abusive behavior	☐ CURRENT	☐ PAST HISTORY	☐ NO HISTORY
Drug / Alcohol abuse	☐ CURRENT	☐ PAST HISTORY	☐ NO HISTORY

1. Have there been any legal, family, or medical problems as a result of substance abuse? ☐ YES ☐ NO
2. Has substance use complicated psychiatric treatment? ☐ YES ☐ NO

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

C. Past psychiatric treatment (including medications) and response:

MEDICAL HISTORY:

PLEASE ATTACH COPIES OF RECENT RECORDS / REPORTS

A. Medical & physical illness history (including any surgeries or physical trauma):

B. Current physical illnesses:

C. Any physical limitations / restrictions? ☐ YES ☐ NO

DESCRIBE:

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Current Medications:

MEDICATION	DOSE	ROUTE	SCHEDULE	HOW LONG?

Any PRN medications and for what target symptoms:

MEDICATION	DOSE	ROUTE	FREQUENCY	PURPOSE

Allergies & Reactions: ____________________

Physician's Name: ____________________

Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Phone:____________________ Email: ____________________

Signature: ____________________ Date: ____________________

NAMES OF OTHER SUPPORTING PROFESSIONALS:

Name: ____________________ Phone:____________________ Email:____________________

Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Name: ____________________ Phone:____________________ Email:____________________

Address: ____________________

City: ____________________ State: __________ Zip Code: __________

THE APPLICANT MUST BE AT LEAST 18 YEARS OLD. ROSE HILL DOES NOT DISCRIMINATE ON THE BASIS OF RACE, ETHNICITY, NATIONAL ORIGIN, SEX, AGE, RELIGION, CREED, OR SEXUAL ORIENTATION.

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PLEASE INCLUDE AREAS OF CONCERN AND OBSERVATION OF INSIGHT AND JUDGEMENT