Document Type: Referral Form
Abbreviation: BHRF

Geri Psych Referral

Patient Name:		**Age:**	**Sex:**
Address:		**DOB:**	
City/State:	**ZIP:**	**Marital Status:**	
Telephone:	**Social Security #**		
Next of Kin:	**Relationship:**		
Address:	**City/State**	**Zip:**	
Primary Phone:			
Legal Status	**Voluntary** ☐	**Involuntary** ☐	

CURRENT CONDITIONS

Presenting problems – Unusual behaviors:

When did problem start?

Have you had treatment for these symptoms in the past? Yes ◯ No ◯

History of relevant psychiatric treatment:

Current Level of Functioning:

Patient Label

Owensboro Health

Current Medical Conditions:
Current Living Arrangements:
Plans for Living Arrangements on Discharge:

Referral Source Information

Contact Name:	
Organization:	
Address:	
City/State:	**ZIP:**
Telephone:	
Fax:	

Please attach:

- Current medication list
- Current labs (within last 24 hours), including: CBC, CMP, TSH, UDS, UA, lithium and/or depakote levels (as applicable), BAL, Vitamin B12, Magnesium
- Most recent doctor visit/progress note (if available)
- Current EKG (within last 24 hours)

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Please note, we cannot accept patients who are on supplemental oxygen, currently on dialysis, receiving any IV medications, patients with tracheostomies, or who would be unable to leave their room to participate in treatment.

Patients must be willing to sign in for voluntary admission. If the patient does not have capacity for medical decision making, next of kin must be available for consent.

Patient Label

Owensboro Health