



Bridges Counseling Connection

<https://www.bridgescounseling.org>

Office: 907-771-0536 • Fax: 907-771-0537

Referral Form

Date:

Referring Provider:

Referring Office Phone:

PATIENT DEMOGRAPHIC INFORMATION (or attach EHR demographics)

Patients Name:

DOB: Phone Number:

Physical Address:

Guardian Name (if applicable): Guardian Phone Number:

Relationship to Patient:

INSURANCE INFORMATION (or send EHR demographics)

Primary Insurance Company: Member ID#

Group ID# Guarantor Name:



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Guarantor DOB: Guarantor relationship to patient:

CLINICAL INFORMATION (or attach last relevant note)

Reason for Referral (Check one): ☐ Therapy
☐ Medication Management
☐ Neuropsychological Testing

If you've selected Neuropsychological Testing please include a short note in the space below stating what they're to be tested for, symptomology and how it affects functioning/life.

Diagnosis

Current Psychiatric Diagnosis:

Relevant Medical Diagnosis:

Current Psychiatric Treatment

Current Symptoms:

Current Suicidal / Homicidal Thoughts? No ☐ Yes ☐

Details:

Current Medications (psychiatric or otherwise, please include dose. **Attach list if preferred**):



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