# Bridges Counseling Connection

8717 Dimond D Circle • Anchorage, AK 99515
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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