PT REFERRAL
HARBORCREST BEHAVIORAL HEALTH

FAX TO: CRISTEN ROGERS, BA, CDP **AT: (360) 537-6275**

PATIENT:____ **INSURANCE:** ____________________________

SSN:__________________________________ **ADDRESS:**____

PHONE: __________________________ **DOB:**_______________ **DRUG OF CHOICE:** _________________________

SMOKER: YES NO (CIRCLE ONE) **** IS PT SUICIDAL/HOMICIDAL: YES NO (CIRCLE ONE)**
****RECENT ATTEMPTS**____

PRIOR TX?:___________________________________ **MALE FEMALE**

ALLERGIES:_________________________________ **PREGNANT: YES NO DUE:**____________________________

PSYCH ISSUES (DEPRESSION, ANXIETY, PTSD, BIPOLAR, ETC) ****DIAGNOSED ONLY****:____

MEDICAL ISSUES (DIABETIC, SLEEP APNEA, LUNG, HEART, LIVER, ETC):____

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DOES PT SUFFER FROM ONGOING PAIN? YES NO

IF YES, PLEASE EXPLAIN (CAR WRECK, SURGERIES, ETC):____

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SKIN ISSUES (OPEN SORES, MRSA, ETC.):____

DOES PT NEED ASSISTANCE WITH DAILY ACTIVITIES (SHOWERING, ETC) **YES NO**

IS PT. AMBULATORY (ABLE TO GET AROUND WITHOUT HELP)**: YES NO**
DEVICES OF ASSISTANCE USED (WHEELCHAIR, CANE, WALKER, ETC)____

LEGAL ISSUES:____

PRIMARY/OB DOCTOR:____

MEDICATIONS:____

COMMENTS:____

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