Psychotherapy Referral Form

CLARUS HEALTH ALLIANCE
150 Otrobando Avenue
Norwich, CT 06360
t: 860.889.7274
f: 860.889.2131

Referring Provider: _____ NPI: _____

Organization: _____ Phone: _____ Fax: _____

Patient Information:

Last Name: _____ First Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Gender: ☐M ☐F ☐Trans ☐NB

Contact *(if other than patient)*: _____ Phone: _____ Relationship: _____

Insurance Information:

Primary Insurance Carrier: _____ ID#: _____ Group#: _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Secondary Insurance Carrier: _____ ID#: _____ Group #: _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Reason for Referral (check all that apply):

- ☐Sadness/Helplessness
- ☐Substantial Life Change
- ☐Recent Loss
- ☐Family Issues
- ☐At Risk
- ☐PTSD
- ☐Recent Psychiatric Hospitalization
- ☐Legal/Probation/Court Mandated
- ☐Behavior/Conduct
- ☐Emotional Mental Illness
- ☐Social/Interpersonal Challenges
- ☐Employment Instability
- ☐Educational Instability
- ☐Unhealthy Coping Mechanisms
- ☐Substance Use/Abuse
- ☐Other:
- ☐Trauma History
  - ___ Physical
  - ___ Emotional
  - ___ Sexual Abuse
  - ___ Witness to Significant Harm of Loved One(s)
  - ___ Natural Disaster
  - ___ Military

Symptoms and Behaviors of Risk (check all that apply):

- ☐Anxiety/Panic
- ☐Depressed Mood
- ☐Adjustment Challenges
- ☐Manic Mood
- ☐Self-Care Deficit
- ☐Physical Pain/Discomfort
- ☐Impulsivity/Hyperactivity
- ☐Concentration/Inattention
- ☐Social Withdrawal
- ☐Sensory Issues
- ☐Obsessions/Compulsions
- ☐Isolative Behaviors
- ☐Psychotic Features
- ☐Self Harm
- ☐Suicidal Ideations/Attempts
- ☐Homicidal Ideations/Attempts
- ☐Physical Aggression
- ☐Verbal Misconduct
- ☐Changes in Appetite
- ☐Changes in Sleeping Pattern
- ☐Other:

Current Diagnoses:

Please Detail Presenting Problem:

Thank you for your referral