New Patient Referral

Today's Date: _______________ **Referring Agency**: _______________________

Contact Name: _______________________ **Contact Number**: _______________________

Contact Email address: ____

Referral Recommendations: ☐ IOP (Intensive Outpatient Program) ☐ RMH (BST/PSR)

☐ Individual Therapy ☐ Primary Care ☐ Psych Eval/Med Mg- ☐ Case Management

☐ Medication Assisted Therapy ☐ Medical Detoxification CTC) ☐ Crisis Stabilization (CTC)

☐ Supportive Housing ☐ Women's Services ☐ HomeBase

☐ Adolescent/Child Services: ☐ Therapy (Child/Family ☐ Psychiatry

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Name of Referral: ______________________________________ **DOB**:____/____/_______

Preferred Contact Method: Call Text Email - **Can we send appointment reminders?** Yes No

Phone Number: (____) __________________ **Email**: ______________________________

Current Address: ____

Gender: M F Trans F Trans M Other: ____________ Prefer not to answer: ________

SSN: ________-_______-__________ **Current Marital Status**: _______________________

Health Insurance: _______________________ **Health Insurance#**: ____________________

Are you the Primary insured? Yes No Relation to Primary: _________________________

If no, name of primary insured: ____

Primary Insured DOB: _____/____/_________ Employer: _____________________________

Have you ever received Well Care Services? Yes No If so, when? ____________________

What services did you receive from Well Care? ___________________________________

Recent Hospitalizations (when, for what): ______________________________________

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Well Care Behavioral and Medical Clinic, 850 Mill St. Suite 100, Reno NV 89502
Phone (775) 538-6700 Fax (775) 668-5878

List any physical concerns you are having at present: (e.g., high blood pressure, headaches, dizziness etc.): ____
____
____
____

What prescription and over the counter medications (and dosage) are you taking at present, and for what purpose?

Name	Dose	Frequency	Reason

Have you participated in therapy before? YES NO

When	Where	Reason

Have you participated in Intensive Outpatient Programs (IOP) before? YES NO

When	Where

Is there anything else you would like us to know about you?
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