



**REFERRAL FORM FOR PSYCHIATRIC EVALUATION**

Please fax referral to (501) 620-5325      Attention: Bariatric Psych Evals (Amanda Wolf LPN)  
Referral must be faxed from your referring physician's office

Referring Info		
Referring Doctors Name:	Referral Date:	
Do you have a release signed by client to send information to us?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Reason for Referral:		

Demographics	
Client Name:	Date of Birth
Daytime/Message Phone:	

Payor Source	
Insurance: none	<input type="checkbox"/> Check if

History		
Has Client had any prior hospitalizations or treatment (substance or psychiatric)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Where:	
	Dates of hospitalization:	
	Reason:	
Is Client currently taking benzodiazepines (Valium, Xanax, Ativan, Librium, Klonopin) or on a stimulant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Current Medications:		