Therapy Referral Form

Refer a patient to a licensed therapist, facilitate their transfer, and document their basic information and medical background for reference.

Healing Haven Hospital

Phone: 123-456-7890
Email: hello@reallygreatsite.com

Address: 123 Anywhere St., Any City, ST
Website: www.reallygreatsite.com

Patient Information

Patient Name:	@name here
Date of Birth	January 30, 2030
Gender Assigned at Birth:	Details here
Address:	123 Anywhere St., Any City, ST
Contact Information	**Phone Number:** 123-456-7890
	Email: hello@reallygreatsite.com

Reason for Referral

Explain the reason for the patient or client's referral. You may use bullet points to keep this section clear and concise.

Is this referral urgent?	Yes/No

Patient History

Current Medications:	• Medication, dosage, and schedule here • Medication, dosage, and schedule here • Medication, dosage, and schedule here
Notable conditions:	• Condition or diagnosis here • Condition or diagnosis here • Condition or diagnosis here
Alcohol Consumption:	☐ Yes ☐ No
Drug Use:	☐ Yes ☐ No
Tobacco Use:	☐ Yes ☐ No

Other Comments

Use this section to highlight any relevant observation or information related to the patient's condition or diagnosis.

Signature here

Referring Physician here Date: January 30, 2030

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