4 2 Restore, LLC • 3527 N Rolling Rd., Ste. 4 • Windsor Mill, MD 21244 • (410) 701-9190

Referral Form

Referral Source: _____ ☐ Adult ☐ Minor Date: _____

Consumer Information

Name: _____ DOB: _____ Gender: SS#: _____

Address: _____ City: _____ Zip Code: _____

Phone#: _____ Alt Phone: _____ Highest grade completed: _____

Emerg Contact: _____ Emerg Contact #: _____ MA#: _____

Race: ☐ African American ☐ Caucasian ☐ Asian ☐ Latino ☐ Native American ☐ Native Hawaiian

# of Arrests in the last 30-Days: ____

Employed: ☐ Yes ☐ No Veteran: ☐ Yes ☐ No Name of war served in: _____

Referral Information

Are you taking any medication(s): ☐ Yes ☐ No Please list: _____

Presenting Problem(s)/Diagnosis (if known, i.e. – PTSD, Anxiety, Bipolar, Depression, Panic Attacks)

Have you ever been seen by a Psychiatrist? ☐ Yes ☐ No If "Yes", list name _____

When were you last seen? _____

☐ Suicide Risk ☐ Danger to Self/Others ☐ Urgent/Critical Medical Condition ☐ Immediate Treatment(s)

Other

Do you have trouble walking up stairs? ☐ Yes ☐ No Are required to use a walker? ☐ Yes ☐ No

Are you required to use a wheelchair? ☐ Yes ☐ No Do you use a cane? ☐ Yes ☐ No

Do you need any additional accommodations? ☐ Yes ☐ No Explain: _____

Preferred appointment day/time: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ AM ☐ PM

Counselor Information

Counselor Name: _____ Phone#: _____

E-mail Address: _____

Referral Source: _____ Relationship to Consumer: _____

Referral Phone#: _____ Person completing form: _____