STOKES COUNSELING

Psychiatric APRN Referral Form

Referral Date:

Demographic Information

Client Name:

Preferred Pronouns:

Address:

Email:

Phone Number(s):

Date of Birth:

Insurance Carrier:

ID Number:

Is this client pregnant or breast feeding? ☐ No ☐ Yes

Is this client involved in a DCF case? ☐ No ☐ Yes

If this client is involved in a DCF case, please provide the name and phone number of the DCF caseworker:

Medication Information

Is the client currently prescribed or wanting to be prescribed stimulants (Concerta, Ritalin, Focalin, Adderall, Vyvanse) for ADHD?

☐ No ☐ Yes

Is the client currently prescribed or wanting to be prescribed Benzodiazepines (Xanax, Librium, Klonopin, Valium, Ativan, Ambien) for Anxiety or Insomnia?

☐ No ☐ Yes

Current Medication

Medication	Dosage	Frequency	Prescriber

Past Medication

Medication	Dosage	Frequency	Prescriber

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Psychiatric History

Provider Name	Level of Care	Dates of Care	Outcome

Primary Care Information

PCP Name:

PCP Contact Information:

Preferred Pharmacy/ Location:

Reason for Referral (Symptoms, Presenting Problem(s)

Is the client open to a more holistic approach? ☐ No ☐ Yes

Can the client understand/make decisions regarding their own healthcare?

Clinician Information

Name: **Phone:**

Email:

Please send referrals to: APRN@stokescounseling.com
Questions? 203-729-0341