INTEGRATIVE
THERAPEUTIC SOLUTIONS, LLC.

OUTPATIENT REFERRAL FORM

☐ **Initial Referral** ☐ **Returning Patient** ☐ **Approximate Date of Last Visit:**

Referral Information:

Date of Referral: _____ Source of Referral: _____

Address: _____ City: _____ State: _____ Zip: _____

Is the patient aware of referral? Yes _____ No _____

Consumer Information:

Name:			**Date of Birth:**	**Age:**	
Address:		**City, State, Zip:**			
Sexual Orientation	☐ **Heterosexual** ☐ **Gay/Lesbian** ☐ **Bisexual** ☐ **Something Else, Please Describe:** ☐ **Don't Know** ☐ **Decline**		**Language Preference:**		
Race/Ethnicity:	☐ **Amer. Indian/Alaskan Native** ☐ **Asian** ☐ **White** ☐ **Black/African American** ☐ **Native American / Hawaiian or Other Pacific Islander** ☐ **Hispanic** ☐ **Non-Hispanic**				
Gender Identification	☐ **Male** ☐ **Female** ☐ **Transgender Male/Trans Man/(F to M)** ☐ **Transgender Female/Trans Woman/(M to F)** ☐ **Genderqueer (or gender nonconforming)** ☐ **Additional Gender Category, please specify:** ☐ **Decline**				
Social Security Last 4 digits#:		**MA#**			
Phone #:		**Access to Transportation for On Site Activities:**	☐ Yes ☐ No		
Adult Contact's Name:		**Relationship:**	☐ Parent ☐ Guardian ☐ Foster Care Provider		
Address (If different):		**Does Contact Person Have Legal Custody?**	☐ Yes ☐ No		
City, State, Zip:		**Phone Number:**			

Is the consumer experiencing problems at home, in the community, and/or school? ☐ Yes ☐ No

Is the consumer having difficulty in the following areas?

Staying focused and organized? ☐ Yes ☐ No ☐ Unknown
Managing behavior? ☐ Yes ☐ No ☐ Unknown
Establishing positive peer relationship? ☐ Yes ☐ No ☐ Unknown
Respecting Authority figures? ☐ Yes ☐ No ☐ Unknown

Current grade completed: _____ **School:** _____

Employed? ☐ Yes ☐ No **If Yes, Position & Where?** _____

Was consumer court-ordered to seek psychiatric services? ☐ Yes ☐ No
Was consumer previously seen by another mental health facility and/or provider? ☐ Yes ☐ No If yes, please indicate name of facility and/or provider: _____
Past Diagnosis: _____
List any known physical / medical condition(s), if any: _____
List known medication(s), if any: _____

3200 Crain Highway Ste. 205
Waldorf, MD 20603
Phone: (240) 448-2475
Fax: (240) 448 2335

REASON FOR REFERRAL: Please write a brief description of your consumer's presenting problem:

Please make sure consumer presents the following documents at the time of registration and intake:

- ☐ Proof of Identification (Birth Certificate & Social Security Card, Driver License or State Identification Card)
- ☐ Proof of Insurance
- ☐ Bring **all** medications currently taken
- ☐ Copies of Immunization Record
- ☐ Most recent Physical Exam (must be within past year)

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