PATIENT REFERRAL FORM

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ARK INTEGRATIVE MEDICINE

LAST NAME | FIRST NAME | DATE OF BIRTH

ADDRESS | CITY | STATE | ZIP

PHONE | EMAIL

DIAGNOSIS (ICD 10 CODE)

REFERRING PROVIDER | SPECIALTY

REFERRING PROVIDER PHONE

REFERRING PROVIDER EMAIL

REASON FOR REFERRAL (CHECK ALL THAT APPLY)

- ☐ **Depression**
- ☐ **General Anxiety Disorder**
- ☐ **Complex Regional Pain Syndrome (CRPS)**
- ☐ **Obsessive/Compulsive Disorder**
- ☐ **Bipolar Disorder**
- ☐ **Neuropathic Pain**
- ☐ **Post-Traumatic Stress Disorder**
- ☐ **Fibromyalgia**
- ☐ **Migraines/Daily Headaches**

REFERRAL PROVIDER COMMENTS

CURRENT TREATMENTS

MEDICAL MANAGEMENT

PSYCHOTHERAPY

OTHER

PRE-REFERRAL CHECKLIST (NOTE: ALL BOXES MUST BE CHECKED PRIOR TO CLINIC ADMISSION)

- ☐ **Patient is not actively suicidal**
- ☐ **Patient is <u>not</u> actively abusing opioids or other illicit substances**
- ☐ **Patient consents to referral and understands the clinic obligations**

REFERRING PROVIDER SIGNATURE: | DATE SIGNED: (MM/DD/YYYY)

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