SFMC REFERRAL
To Medical Clinic From Behavioral Health Clinic

Referring Provider: **Date of Referral : _____**

Patient's Name: _____ **Phone #: _____**

Gender: Male Female **Age: _____**

Warm Handoff Done: Yes No

REASON FOR REFERRAL

Needs adjustment or addition of medication for behavioral health problem:

Medication:_____ Current Dosage:_____

Adjustment or addition suggested: _____

Side effect problems:

With BH medication: _____

With Other medication: _____

Other Medical problem: _____

_____

Patient Referral

If not seen today visit with Medical scheduled? Yes No Date scheduled: _____

FOR MEDICAL CLINIC ONLY

Date seen at Clinic _____ Patient did not show up

Medical Provider Initials _____ Patient not seen for other reasons