HFI Outpatient School Referral Form

Please email to :
outpatientreferrals@hfi-pgh.org
OR Fax to: Becky @
412-766-0476 Phone:
412-766-9020 x1222

Date: _____ **Referred by:** _____

School Location: _____ **Guidance Counselor:** _____

Client's Name: _____

Gender: _____DOB: _____ SS Number: _____

Address: _____

Guardian's Name: _____ Phone: (C)_____(W)_____

Address: _____

Relationship to client: _____ Email: _____

Guardian's Name: _____ Phone: (C)_____(W)_____

Address: _____

Relationship to client: _____ Email: _____

Lives with:_____ **Primary Contact :** _____

Emergency Contact: Name: _____

Phone: (C)_____(W)_____Relationship: _____

Insurance Name: _____

ID#: _____ Group #: _____

Policy Holder: _____ Relationship to client: _____

Secondary Insurance: Name: _____

ID#: _____ Group #: _____

Policy Holder: _____ Relationship to client: _____

If you have state/medicaid insurance have you ever had commercial/private insurance before: _____

Name of insurance: _____Approximate date: _____

Reason for referral:

☐ Anger	☐ Depression	☐ Lack of focus	☐ Physical aggression	☐ Relationship Issues	☐ Stress
☐ Anxiety	☐ Impulsive	☐ Makes poor choices	☐ Verbal aggression	☐ Learning Disabilities	☐ Self Harm
☐ Behavior Issues	☐ Hyperactivity	☐ Mood Changes	☐ Suicidal Thoughts	☐ School Problems	☐ Social Issues

☐ Other: _____

_____

Psychiatric Medication(s): _____

_____

Who is prescribing the medication(s): _____

Do you want to see the psychiatrist for an evaluation and medication management: _____

**Starts with your therapist's referral for an evaluation. Records must be received before seeing the psychiatrist.*

**Must be compliant with therapy & therapy must continue even once seeing the psychiatrist.*

Are you currently receiving any other therapeutic services? ☐ Yes ☐ No

Current PCP: Practice Name: _____

Doctor: _____ Phone#: _____

Address: _____ Fax # _____

Previous PCP: **If not with current PCP for 5 years*

Practice Name: _____

Doctor: _____ Phone#: _____

Address: _____ Fax # _____

Current therapist/psychiatrist: Practice Name: _____

Doctor: _____ Phone#: _____

Address: _____ Fax # _____

Previous therapist or psychiatrist: **If not with current PCP for 5 years*

Practice Name: _____

Doctor: _____ Phone#: _____

Address: _____ Fax # _____

I _____ give _____

(Parent/Client's name) *(School name)*

permission to submit the referral form and speak with Holy Family Institute Outpatient department regarding the status this referral.

_____ Date: _____

(Parent/Client's Signature)

Internal Use (Please do not write/complete the section below)

Date Received _____

Financial Responsibility: _____

_____

Advised client/parent of financial responsibility:

Name: _____ Relationship:_____

Intake taken by: _____

Assigned to: _____