TRAVELING LIGHT
PSYCHIATRIC SERVICES
Serving Central Minnesota

Behavioral Health Referral Form

Name of patient: _____DOB:_____

Referring physician: _____

Referral submitted by: _____Phone Number: _____ Is the patient their own decision maker? ☐ Yes ☐ No If yes – aware of referral? ☐ Yes ☐ No

Name of decision maker (if other than patient):_____

Phone number for decision maker:_____

Pertinent medical diagnosis:_____

Recent falls:_____Recent illness/ infection:_____

Last Head CT: _____ Results: _____Last U/A: _____ Results: _____

Lab work within last year_____

Presenting Problem

Briefly describe concerns and/or unusual behaviors reported by patient, family, physician, staff, etc.:

Recent Medication Changes:_____

Pharmacy Of Choice:_____

Previous Psychiatric Treatment:_____

Patient Experiencing (check all that apply): ☐ New onset confusion ☐ Multiple falls ☐ Increased isolation ☐ Increased anger ☐ Delusions / hallucinations ☐ Lack of appetite ☐ Increased anxiety / depression ☐ Paranoia ☐ Agitation (describe):_____ ☐ Change in level of functioning (describe): _____

Restlessness	**Verbal Aggression**	**Physical Aggression**
☐ Pacing / rocking	☐ Screaming	☐ Biting
☐ Jumpiness	☐ Swearing	☐ Hitting
☐ Inappropriate social behavior / pointing	☐ Complaining	☐ Kicking
☐ Irritability	☐ Constant requests for attention	☐ Hurting self and/or others
☐ Shakiness	☐ Being negative	☐ Inappropriate physical behaviors (sexual advances, spitting, scratching, slamming doors)
☐ Repetitive mannerisms ☐ Wandering	☐ Emotional outbursts	☐ Destroying things
☐ Hoarding	☐ Strange noises (unwarranted laughter, crying)	☐ Throwing things
	☐ Inappropriate language (cursing, sexual advances)	☐ Resisting help
	☐ Repetitive questions or sentences	

Please include with referral (last two weeks):

☐ Insurance Information ☐ Patient's Face Sheet ☐ Nurses' notes / behavior documentation ☐ Current medication list ☐ Last MD note ☐ Ancillary notes from other providers supporting concerns

Please fax completed referral form and supporting information to 218-454-0441