Power Mental Health Services, inc.
Psychiatry/Medication Referral Form

Clients Legal Name: _____

Clients Lived Name: _____ **DOB:** _____

Gender: _____ **Preferred Pronouns:**_____

Address: _____ **Phone #:** _____

Insurance: _____ **Member #:**_____

Contact Name (if other than the client)**:** _____

Contact Phone #: _____

Referral Source: _____

Reason for Referral: ☐ Diagnostic Evaluation ☐ Anxiety Disorder
☐ Medication Management ☐ Depressive Disorder ☐ Bipolar Disorder
☐ Depressive Disorder ☐ Schizophrenia ☐ Other:_____

Presenting Concerns:

Current Medications:

Recent Hospitalizations: ☐ Yes ☐ No **If yes Release Date:**_____

Please email the completed form and insurance card to
referrals@powermentalhealthservices.com