F.A.S.T
BEHAVIORAL HEALTH CLINIC

REFERRAL FORM

** Please call the clinic: 817-987-1079 to confirm your urgent appointments*

Please complete and/or have the patient answer the questions, as appropriate.
Attach progress notes & relevant labs/imaging reports.

BEHAVIORAL HEALTH
* Psychopharmacology
* Psychotherapy

REFERRAL FAX #: 817-422-0781

A. REFERRING SOURCE	Date of referral:		
Facility Name:		Medical Record Number:	
Type of Facility: ☐Emergency Room ☐Inpatient ☐Outpatient ☐ PCP ☐Other:			
Name and title of referring source:			
Phone number:		Fax Number:	
Referring Provider:		Specialty:	
Phone number:		Fax Number:	
B. PATIENT INFORMATION			
Patient Name:		Date of Birth: / /	
Gender: Male ☐ Female ☐			
Language:			
Address:			
Best Contact Phone:	Alternate Phone:	Email:	
C. INSURANCE INFORMATION			
Company:		Policy Holders Name:	
Policy ID#:	Group#:	Insurance phone #:	
D RELEVANT CLINICAL INFORMATION			
Reason for Referral/PresentingProblem: _____			

E. Behavioral Health Issues: Please, indicate the symptoms the person has experienced:

Symptom	Past	Recent	Current	Description of symptom(s)
¤ **Suicidal Ideation/Attempt**	☐	☐	☐	***** If patient experiencing ACTIVE suicidal thoughts with plan & intent to hurt themselves please Call 911 or facilitate the transfer of patient to nearest ER or in -patient psychiatric facility**
☐Psychosis	☐	☐	☐	☐Command hallucinations ☐Paranoia
☐Mood Instability	☐	☐	☐	☐Agitation ☐Impulsiveness ☐Self-mutilation behavior ☐Irritability
☐Depression	☐	☐	☐	☐Low energy ☐Low concentration ☐Little pleasure ☐Fatigue
☐Anxiety	☐	☐	☐	☐Restlessness ☐Nervousness ☐Panic Attacks ☐Feeling tense
☐Post-Traumatic Stress	☐	☐	☐	☐Hx of Trauma ☐Avoidance ☐Flash Backs ☐Hypervigilance
☐Cognitive problems	☐	☐	☐	Dementia: ☐ yes ☐ no
☐H/O Aggressive Behavior	☐	☐	☐	☐Damaging property ☐Required seclusion/Restraint ☐Homicidal Ideation, Explain:
☐Patient Taking Lithium	☐	☐	☐	If current or recent: Last Levels: Date:_____ MeasureLevel: _____
☐Patient Taking Valproic Acid	☐	☐	☐	If current or recent: Last Levels: Date:_____ MeasureLevel: _____
☐Patient Taking Benzodiazepines	☐	☐	☐	Patient taking any, but not limited to the following: Xanax, Valium, Klonopin, Ativan

Please describe any of the above checked behavior in detail including what, when, precipitant and **how the behavior was stopped**: