Healthy Foster Care America

# REFERRAL AND FEEDBACK FORM

Medical Record No. or Stamp

Date: _____ ❑ Initial ❑ Follow Up

Referring physician name: _____

Address: _____
(Street/PO Box) City State Zip

Fax: ( ) _____ Phone: ( ) _____

**Patient's** name: _____ DOB: _____

**Parent's** name: _____ Phone: ( ) _____

Address: _____
(Street/PO Box) City State Zip

Date(s) patient seen: _____

Reason(s) for referral: _____

_____

_____

_____

Any specific questions or requests: _____

_____

_____

_____

Referring physician's printed name / signature

Thank you for evaluating this patient. To facilitate communication and treatment, please **mail or fax** this document (both pages) to the physician listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your collaboration.

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**Patient's** name:_____ DOB: _____

**Parent's** name: _____ Phone: (  ) _____

Address: _____
(Street/PO Box) City State Zip

Date(s) patient seen: _____

❑ Patient did not make appointment

❑ Patient made an appointment but did not keep appointment

❑ Patient not seen within 60 days

Initial diagnosis:

1. _____
2. _____
3. _____

Recommendations: _____

_____

_____

_____

Medications prescribed: _____

_____

_____

_____

Follow-up planned:

❑ Medication management
❑ Individual therapy
❑ Family therapy
❑ Medical lab requests
❑ A comprehensive note or consult is on the way
❑ Referral for additional diagnostic testing
❑ Return to your care for medication management
❑ Recommend follow-up in _____ weeks
❑ Other: _____

_____
Name (type or print) Signature

Disclaimer: