IMPORTANT
Please Send Copy of Patient's Insurance Card With Referral

Arbor Mental Health Center
500 N. 3rd St., Suite 220
Wausau, WI, 54403
Phone: (715) 204-4260
Fax: (844) 927-0227
Email:ContactUs@ArborCenter.or

GENERAL REFERRAL FORM

PART I: REFERRING PROVIDER INFORMATION	
Referring Provider:	Date:
Practice Name:	Primary Provider ☐ Other:
Phone:	Fax:
PART II: PATIENT INFORMATION	
Patient Name:	Gender:
Date of Birth:	Parent/Guardian:
Insurance:	Phone:
Address:	
PART III: CLINICAL INFORMATION	
Reason for Referral:	

Diagnosis (list confirmed if known, if not list suspected) Primary Psychiatric Diagnosis

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Secondary Psychiatric Diagnoses (including substance abuse) ______________________

Relevant Medical Diagnoses ______________________

Relevant Social Factors ______________________

Past Psychiatric History (hx) and Treatment (please check appropriately):
Hx of violence? No Yes, details ______________________

Hx of suicide attempts? No Yes, details ______________________

Hx of psychiatric hospitalizations? No Yes, details ______________________

Current Psychiatric Treatment & History Current Symptoms:
Current suicidal / homicidal thoughts? No, Yes, details ______________________

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