Date of Referral: ___________________________

Patient Name:_______________________

Date of Birth:_______________________

______________________________________
Clinician/Facility

______________________________________
Address

________________ __________________
Phone Fax

Dear ___________________________:

I am referring the above patient to you for the following:

[ ] Individual Psychotherapy
[ ] Family Psychotherapy
[ ] Couples Psychotherapy
[ ] Psychiatric Assessment
[ ] Other: _____________________
[ ] Neuropsychological Testing
[ ] Educational Testing
[ ] Psychological Testing
[ ] Medication Management

**CONCERNS:**

[ ] Depression
[ ] Emotional Liability/Mood Disorder
[ ] Anxiety
[ ] PTSD
[ ] Irritability
[ ] Sleep Problems
[ ] Poor Reality Testing
[ ] Behavioral Issues
[ ] Parenting
[ ] Grief/Loss
[ ] Interpersonal Issues
[ ] Communication
[ ] Self-Esteem/Identity Issues
[ ] Attention/Concentration
[ ] Memory
[ ] Learning Disability
[ ] School/Academic Problems
[ ] Vocational/Work Problems
[ ] Substance Abuse (specify below)
[ ] Body Image/Eating Disorder
[ ] Other:______________

**COMMENTS:**_____________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Sincerely,

________________________________ ________________________________
Practitioner's Name Signature