

# Serenity Place, LLC

22655 Washington Street  
Leonardtown, MD 20650  
Phone: (301)690-8008 Fax: (312)260-7996  
appointment@serenityplace.biz



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## Mental Health Referral

### ***Referral Information***

Office/Facility: \_\_\_\_\_

Referral Date: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Reason: \_\_\_\_\_

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Services Requested:  **Therapy**  **NP Psychiatry**

### ***Client Information***

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Guardian/Parent Name (if applicable): \_\_\_\_\_

Relationship: \_\_\_\_\_

Guardian Phone Number (if applicable): \_\_\_\_\_

Guardian Email (if Applicable): \_\_\_\_\_

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## Mental Health Referral

### *Client Insurance Information*

Insurance Plan: \_\_\_\_\_  
Policy Number & Group Number (if applicable): \_\_\_\_\_  
Insurance Policy Holder Name: \_\_\_\_\_  
Policy Holder DOB: \_\_\_\_\_  
Policy Holder Phone Number: \_\_\_\_\_  
Policy Holder Email: \_\_\_\_\_  
Client Relationship to Policy Holder: \_\_\_\_\_

### *Additional Client Information*

Presenting Complaint: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Symptoms & Behaviors of Risk \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Past Psychiatric History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Past Medical History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
History of Drug/Alcohol Misuse: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Other Relevant Information:

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BY SIGNING BELOW, I attest that the information submitted on this form is complete and accurate, and I am authorized to submit this referral.

x \_\_\_\_\_

Referrer Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referrer Credentials: \_\_\_\_\_