



Rutland Regional Medical Center

Behavioral Health Clinic

160 Allen Street
Rutland, VT 05701
802.747.1857

Fax completed form to 747-0129

Referral Form

Referral From: _____ **Phone:** _____

Referral to which services(s): O/P Dx. Eval. & Psychiatric Consult Outpatient Counseling
 Inpatient Consultation Psychological Ax. / Testing

Patient Name: _____ **DOB:** _____

Address: _____ **Phone:** (h) _____
(w) _____

Reason for Referral: _____

Precipitating Events: _____

Current Psychiatrist or psychiatric medication prescriber

Name: _____

Address: _____ **Phone:** _____

Other Mental Health Care Providers:

Name: _____

Address: _____ **Phone:** _____

Name: _____

Address: _____ **Phone:** _____

Previous Psychiatric Treatment:

Provider	Where	When	Reason	IP or OP
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Insurance Information

Insurer _____ **Phone:** _____

Policy Holder _____

Policy Number _____

Consult / Referral Ordered by: _____ **Date:** _____

The above information will be reviewed by BHC professional staff by the end of the next business day. You will be contacted by phone regarding our ability to accept the referral. We may also request additional information prior to acceptance of a referral.

Please attach the following information:

___ List of all current medications

___ Copy of most recent H&P

For BHOC Use Only

Rec'd: _____

Resp: _____

Provider: _____

Pt. Notified: _____

Appt: _____