LANDMARK CENTER
FOR BEHAVIORAL HEALTH

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Wallingford, Connecticut 06492
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Referral Form For Psychiatric Evaluation

Referring Doctor or
Clinician_____
Address_____
Telephone # _____
Fax#_____

Patient Name_____
DOB_____
Telephone # _____
Insurance Company _____
(We do not take Medicaid or Medicare)

Reason For Referral (Check All That Apply):

Depression
Bipolar
Anxiety
ADHD
Trauma/ PTSD
Explosiveness
Suicidal Behavior
Psychosis
Autism/ PDD/ Aspergers
Other/ Specify

Brief, pertinent history

_____
_____
_____
_____

Other issues or concerns

_____
_____
_____
_____

HIPPA COMPLIANT RELEASE SIGNED AND ATTACHED: o YES o NO