Geriatric Psychiatry Clinic
240 E Morris Ave #400
Salt Lake City, UT 84115
FAX#: 801-585-5723

GERIATRIC PSYCHIATRY CLINIC REFERRAL FORM

REFERRAL SOURCE		
Referring Provider Name:		
Referring Provider Address (incl zip code):		
Referring Provider Phone #:	Referring Provider Fax #:	
Referring Provider Email:		
PATIENT DEMOGRAPHIC INFORMATION		
Patient's Name:		
U Health Medical Record Number (if applicable):		
Address (incl. zip code):		
Home Phone #:	Cell Phone #:	
Date of Birth (MM/DD/YY):	Age:	Sex:
Emergency Contact or Primary Caregiver Name:		
Relationship to Patient:	Contact #:	
PATIENT INSURANCE INFORMATION		
Primary Insurance:	Phone #:	
ID Number:	Group Number:	
Primary Insurance Holder Full Name:		
Primary Insurance Holder Date of Birth (MM/DD/YY):		
Secondary Insurance:	Phone #:	
ID Number:	Group Number:	
Primary Insurance Holder Full Name:		
Primary Insurance Holder Date of Birth (MM/DD/YY):		

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CLINICAL INFORMATION
Reason for Referral:
Please list all psychiatric diagnoses:
Is the patient cognitively impaired or need assessment for cognitive impairment? If yes, provide details.
Does the patient require a caregiver to accompany them to appointments? If yes, provide details.
Does the patient have a history of violence of suicide attempts? If yes, please provide details.
Is the patient currently experiencing suicidal or homicidal thoughts? If yes, provide details.
Relevant medical diagnoses:
Relevant social factors:
Any additional relevant information:

Signature of Referring Provider:_____ **Date:**_____

PLEASE FAX COMPLETED FORM TO 801-585-5723