



RIDGEVIEW INSTITUTE
REFERRAL SOURCE INFORMATION SHEET
 3995 South Cobb Drive
 Smyrna GA 30080
 Assessment: 770-434-4568 EXT: 3200

Fax to: 770-431-7040 Attention: Access Center

For the safety and best interest of your patient, please call the Access Center at 770-434-4568 ext 3200 to verify bed availability before faxing this information. Please note that we can accept this form only via fax. We cannot accept any electronic versions of this form sent via email or scanned and sent via email due to patient privacy concerns.

REFERRAL SOURCE INFORMATION: (please provide your contact information here)

Name: _____ Agency: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Other Number: _____

Should we call you after the assessment? Yes No Direct contact number: _____

****PLEASE NOTE THAT IN ACCORDANCE WITH HIPAA REGULATIONS, IF THE PATIENT DOES NOT SIGN OUR RELEASE OF INFORMATION FORM, GIVING US PERMISSION TO CONTACT YOU, WE WILL NOT BE ABLE TO DO SO****

Level of care request*: _____

*Final level of care determination will be made by the attending physician after the assessment has been completed.

Physician request(s): _____

If your patient is admitted, would you like to be involved in his/her treatment here at Ridgeview? Yes No

PATIENT DEMOGRAPHIC INFORMATION: (please provide as much information about the patient as possible)

Patient Name: _____ Sex: _____ Age: _____ DOB: _____ SS#: _____

Phone (Home): _____ (Cell): _____

Address: _____ City: _____ State: _____ Zip: _____ Co: _____

Emergency Contact Person: _____ Relationship to Pt.: _____

Phone (H): _____ (C): _____

Legal Status of Patient: Voluntary Involuntary: _____

If Child/Adolescent: Who has legal custody? _____

Does someone else have Healthcare Power of Attorney or Guardianship of this patient? Yes No

If yes, name of person who is the patient's guardian or POA: _____

PATIENT INSURANCE INFORMATION: (please provide as much information about the patient's insurance as possible, and fax us a copy of insurance card if available)

Insurance Carrier(s) _____ Policy #: _____ Group #: _____

Name of Subscriber: _____ DOB of Subscriber: _____ SS#: _____

Relationship to Patient: _____ Employer: _____ Verification Phone #: _____

Other phone numbers on insurance card: _____

BRIEF CLINICAL: (please provide current clinical information about the patient)

Presenting Problem(s): Please check all that apply

Suicidal (please describe ideation, plans, attempts): _____

Homicidal (ideation, plans, attempts): _____

Psychosis: _____

Depression: _____

Dementia: _____

Inability to Care for Self: _____

Medication Management: _____

Mania: _____

Anxiety: _____

Eating Disorder: _____

Trauma: _____

Substance Abuse/Dependence Please specify substance(s) quantity, frequency, duration and last known use below:

ADDITIONAL CLINICAL INFORMATION: (if available, we appreciate any information you have about the following)

Precipitating Events or Stressors: _____

Current Medications, Dose and Frequency: _____

Does this patient have a history of violence/violent outbursts? NO YES, describe: _____

Does the patient have any trauma history or survivor issues? NO YES, describe: _____

How long has the patient been under your care? _____

Has the patient had any previous mental health/substance abuse treatment? NO YES, describe below:

Inpatient hospitalization: _____

Partial Hospitalization/Intensive Outpatient treatment: _____

Outpatient treatment, other than with you: _____

Please describe the patient's current medical problems: _____

How will the patient be transported to Ridgeview? Pt will drive self Family/friend will transport pt Ambulance Police

Will the family be involved in the patient's care? _____

Additional Clinical Information: _____

Signature

Date/Time