



Valley Professionals Community Health Center

Psychiatric Referral Form

VPCHC Clinton
777 South Main Street., Ste 100
Clinton, IN 47842

Phone: 765-828-1003 Fax: 765-828-1030

***Referrals will Not be accepted without the following completed information:**

****Please note this referral form is for Psychiatric Medication Management Only.**

Patient Name: _____ Patient DOB: _____
Parent/Guardian Name: _____
Patient Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (____) _____ Cell Phone: (____) _____
Email Address: _____
*Reason For Referral/Specific Psychiatric Concerns: _____

Referring Physician: _____ Contact Person: _____
Office Phone: (____) _____ Office Fax: (____) _____
Primary Physician (if different from Referring Physician): _____

***Please include the following to expedite referral process:**

<input type="checkbox"/> Last Office Visit Notes	<input type="checkbox"/> Recent Labs	<input type="checkbox"/> Medication List
<input type="checkbox"/> Release of Information	<input type="checkbox"/> Any pertinent medical testing	<input type="checkbox"/> Interpreter Needed Y/N
*Please note that in the event of <u>2</u> No Shows to establish with VPCHC Psychiatry, the patient will be ineligible to schedule for 90 days and will require a new referral.		