UNITY PSYCHIATRIC CARE

1400 Rosewood Drive,
Columbia, TN 38401
931-388-6573

QUICK REFERRAL INTAKE FORM

Confidential eFax Line 931 392-4370 • After Hours Confidential Fax Line 931-840-8532

REFERRAL SOURCE

If calling from a facility provide facility name and name of caller.

Facility: _____ Telephone: _____

Your Name: _____ Title: _____

Email Address: _____ Telephone: _____

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/19____ Telephone: _____

Address: _____

Power of Attorney/Guardian Name: _____ Relationship _____ Telephone: _____

Emergency Contact: _____ Relationship _____ Telephone: _____

Legal Status: *Medical POA/Guardianship/Voluntary: If no Medical POA or guardianship available list the name/number of the caregiver/family willing to obtain Medical POA/Guardianship*

_____

Name: _____ Relationship _____

Telephone: _____ Email Address _____

Primary Insurance: _____ Policy Number: _____

Medical and/or Psychiatric Provider: _____

Medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Name of Pharmacy: _____ Allergies: _____

Has the patient received the COVID-19 Vaccine? ❑ Yes ❑ No ❑ No, but patient is interested in learning more

Is the patient currently positive for COVID-19? ❑ Yes ❑ No

Has the patient received a flu vaccine: ❑ Yes ❑ No ❑ No, but patient is interested in learning more

PRESENTING PROBLEMS/BEHAVIORS

List patient behaviors exhibited over the past 72hrs, Including if patient is suicidal and/or homicidal.

_____

_____

_____

_____

Diagnosis of Dementia/Alzheimers: ❑ Yes ❑ No Medical Conditions/Diagnosis: _____

_____

History of Mental illness (*include diagnosis and recent psychiatric hospitalizations*): _____

_____

_____

_____

Full Code or DNR: _____