



THE GATHERING PLACE

5310 S.WILLOW- HOUSTON, TX 77035- PHONE 713-729-3499- FAX 713-729-6870

REFERRAL FORM

Referred By: _____ Agency: _____ Date: _____

Address: _____ Phone: _____ Fax: _____

Psychiatrist: _____ Phone: _____ Fax: _____

Date of last Hospitalization: _____ Where? _____

Precipitating Factors: _____

Diagnosis: Axis I _____ Allergies: Food _____

Axis II _____ Medications: _____

Axis III _____ _____

Current Medications: _____ Dosage: _____

Reason for Referral/Goals: _____

Does he/she have a history of violent behavior? Yes ___ No ___ If Yes, Explain: _____

Does he/she have a history of suicide attempts? Yes ___ No ___ If Yes, When? _____

Does he/she have a history of alcohol and/or drug abuse? Yes ___ No ___ If Yes, Explain: _____

Authorized Signature: _____ **Date:** _____

