



THE GATHERING PLACE

5310 S. Willow Street, Houston, TX 77035 / Phone: 713-729-3799 / Fax: 713-729-6870

Referral Form

Date of Referral: _____

Referent is: Psychiatrist Caseworker Therapist Primary Care Physician

Referent Name: _____ Name of Agency: _____

Address: _____ Phone: _____ Fax: _____

Reason for Referral to The Gathering Place: _____

DSM-IV Diagnosis (Please use DSM Codes for Axis 1 and 2)

Axis 1 _____ Axis 2 _____ Axis 3 _____

Axis 4 _____ Axis 5 _____

Any Known Food or Medication Allergies?

<u>Current Medications</u>	<u>Dosage</u>	<u>Current Medications</u>	<u>Dosage</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Does he/she have a history of suicide attempts? Yes / No If Yes, when was the most recent attempt?

Is he/she currently abusing alcohol and/or drugs? Yes / No If Yes, Please Explain:

Does he/she have a history of Mental Retardation, Alzheimers, Dementia, or Organicity? If yes, Please Explain:

Authorized Signature: _____ Date: _____

Please mail or fax this form along with the most recent psychiatric assessment or psychosocial history.