mindful
URGENT CARE
Mental Health | Addiction

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f: (516) 858-0501
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New York, NY 10001

FOR URGENT REFERRALS WITH ACTIVE SUICIDAL IDEATIONS AND/OR PLAN PLEASE CALL YOUR LOCAL MOBILE CRISIS UNIT OR 911

REFERRAL DATE: _____

Patient Information

FIRST NAME

LAST NAME

PHONE

DOB Month Day Year

GENDER M F Self-describe

REFERRING SOURCE (NAME, PHONE, FAX, BILLING #)

REFERRAL REASON
- Diagnostic clarification
- Consultation/Recommendation
- Medication management

PRESENTING PROBLEMS (SYMPTOMS, DURATION, SEVERITY AND CONTRIBUTING FACTORS

Clinical Features

SUICIDALITY

IDEATION	No	Yes	
PLAN	No	Yes: _____	
ATTEMPTS	No	One	> One
LETHALITY OF ATTEMPTS	Low	High	N/A

SUBSTANCE USE (ALCOHOL & DRUGS)

CURRENT? PAST USE?

TYPE	QUANTITY	FREQUENCY

SELF HARM BEHAVIOR

CURRENT?	No	Yes: _____
PAST?	No	Yes: _____

CURRENT PSYCHIATRIC MEDICATION

AGGRESSIVE BEHAVIOR
- None
- Towards Others
- Towards Property

PAST PSYCHIATRIC MEDICATION

LEGAL CHARGES/INVOLVEMENT
- No
- Yes

PERSONALITY DISORDER TRAITS (BORDERLINE, ANTISOCIAL, AVOIDANT, ETC.)

SYMPTOMS (CHECK ALL THAT APPLY)
- Hyperverbal
- Change in appetite
- Hopeless
- Binging
- Purging
- Restricting
- Obsessions
- Racing thoughts
- Change in sleep
- Helpless
- Anxiety/Panic
- Compulsions
- Irritable/Agitated
- Other: _____

_____
REFERRING PROVIDER NAME

_____
REFERRING PROVIDER EMAIL

_____
REFERRING PROVIDER SIGNATURE

EMAIL THIS REFERRAL TO HELLO@MINDFULURGENTCARE.COM
OR FAX TO (516) 858-0501

Thank you for this referral.