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Please Complete All Information

Patient's Name: _____ DOB: _____ Primary Phone: _____

Primary Insurance: _____ Secondary Insurance: _____

Referral Source: _____ Your Fax #: _____

Please See Patient At: BMI Tyson Place Office BMI Highland Place Office No Preference

Nature of Referral: Pediatric Adolescent Adult Geriatric Couples Family Spanish (Peds only)

Assessment:

- | | |
|---|---|
| <input type="checkbox"/> Comprehensive Psychological Evaluation | <input type="checkbox"/> Opioid/Benzo Medication Risk Assessment |
| <input type="checkbox"/> Comprehensive ADHD Evaluation | <input type="checkbox"/> Pre-Surgical Psychological Evaluation: |
| <input type="checkbox"/> IME/Second Opinion | <input type="checkbox"/> Bariatric <input type="checkbox"/> DCS <input type="checkbox"/> Transplant |
| <input type="checkbox"/> Psycho-Educational Assessment | <input type="checkbox"/> Autism Spectrum Disorder Evaluation |

CBT/Evidence-Based Treatment Protocols:

- | | |
|--|--|
| <input type="checkbox"/> Insomnia/Sleep Disorder | <input type="checkbox"/> Posttraumatic Stress Disorder |
| <input type="checkbox"/> Coping w/ Adult ADHD | <input type="checkbox"/> Panic/Anxiety/Phobia |
| <input type="checkbox"/> Coping w/ Chronic Pain/Headache/Illness | <input type="checkbox"/> Behavioral Parent Coaching (e.g., PCIT) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Trauma-Focused CBT (TF-CBT) for Youth |
| <input type="checkbox"/> Obsessive-Compulsive Disorder | |

Evaluate and Treat:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Academic Issues | <input type="checkbox"/> Anxiety/ Phobia | <input type="checkbox"/> Family Issues | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Behavior Issues | <input type="checkbox"/> Depression | <input type="checkbox"/> Psychotic Disorders |
| <input type="checkbox"/> Adjustment Issues | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Adoption Issues | <input type="checkbox"/> Borderline Personality | <input type="checkbox"/> OCD | <input type="checkbox"/> Self-Harm/ Self-Mutilation |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Cognitive Disorder | <input type="checkbox"/> Panic Disorder | <input type="checkbox"/> Somatoform Disorder |

Psychopharmacology and Specialty Services:

- | | | |
|---|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Psychopharmacology Consult | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> EMDR |
| <input type="checkbox"/> Psychotropic Medication Management | <input type="checkbox"/> Other: _____ | |

Refer To:

- First Available Appropriate Clinician**
- Specific Clinician:** _____

Please Fax Completed Form To:

865-588-6406, Attn: Referral Coordinator. Please attach patient face sheet, copies of front and back of patient's insurance cards, and relevant medical records. We will contact the patient to schedule. You may also reach the referral coordinator by telephone at 865-264-2400, voicemail option 1 or via email at referrals@bmipc.com. Please do not send PHI via email unless encrypted.