Leslie Ann Shields, M.S., L.P.C.

L.A.'s WellBeing Center

Healthy-Living Training, Behavior Coaching, Counseling

106 E.24th St. Houston, TX 77008 PH: 832.858.1411/ FAX: 281-974-2827 la.shields@yahoo.com

Physician's One Page Referral Form

Thank you for your referral of your patient to my practice. I hope this form will make it easier to understand your and your patient's needs. Please fax, email, mail or give to your patient.

This form will be shredded when no longer needed. Use back if more space needed. My current Insurance Panels: Aetna, BCBS, PHCS (Single-case approved for Value Options).

Your Name: ______________________________ Date: ______________________________

Your Contact Details:____________ ____

Do you need to be contacted before I call your patient? _______________________________

How would you like me to brief you on my progress with patient?_______________________

____

Patient Name: ____________________________________ DOB: ___________________

Gender: __________If not adult: Parent(s) Names: ______________________________________

Your Preferred Contact Telephone Numbers and Email Address: ________________________

____

Referral reason, question or concern (Your DX):

____

____

Why now?

____

Safety issues, alcohol or drug use, psychosis, medical problems, recent hospitalization?

____

____

What has worked or not for your patient, if past psychiatric/psychotropic/counseling care?

____

____

What are your patient's strengths? Personal, support systems, etc.

____

____

Patient's
Insurance:____

LA Shields' use

Sponsor's Name (if not self): Sponsor's SSN:

Date Patient Contacted: Date Clinician Contacted: