930 Professional Park Drive
Clarksville, TN 37040
931-538-6420

QUICK REFERRAL INTAKE FORM

Confidential eFax Line 931-392-4370 • After Hours Confidential Fax Line 931-538-6445

REFERRAL SOURCE

If calling from a facility provide facility name and name of caller.

Facility: ______________________ Telephone: ______________________

Your Name: ______________________ Title: ______________________

Email Address: ______________________ Telephone: ______________________

PATIENT INFORMATION

Patient Name: ______________________ DOB: ___/___/19___ Telephone: ______________________

Address: ______________________

Power of Attorney/Guardian Name: ______________________ Relationship ______________________ Telephone: ______________________

Emergency Contact: ______________________ Relationship ______________________ Telephone: ______________________

Legal Status: *Medical POA/Guardianship/Voluntary: If no Medical POA or guardianship available list the name/number of the caregiver/family willing to obtain Medical POA/Guardianship*

____

Name: ______________________ Relationship ______________________

Telephone: ______________________ Email Address ______________________

Primary Insurance: ______________________ Policy Number: ______________________

Medical and/or Psychiatric Provider: ______________________

Medications:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Name of Pharmacy: ______________________ Allergies: ______________________

Has the patient received the COVID-19 Vaccine? ❑ Yes ❑ No ❑ No, but patient is interested in learning more

Is the patient currently positive for COVID-19? ❑ Yes ❑ No

Has the patient received a flu vaccine: ❑ Yes ❑ No ❑ No, but patient is interested in learning more

PRESENTING PROBLEMS/BEHAVIORS

List patient behaviors exhibited over the past 72hrs, Including if patient is suicidal and/or homicidal.

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Diagnosis of Dementia/Alzheimers: ❑ Yes ❑ No Medical Conditions/Diagnosis: ______________________

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History of Mental illness (*include diagnosis and recent psychiatric hospitalizations*): ______________________

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Full Code or DNR: ______________________