Open Arm
Mental Health

NORTHWEST OPEN ARM MENTAL HEALTH

PSYCHIATRIC ASSESSMENT REFERRAL FORM

Referral for Initial Psychiatric Evaluation and Medication Management

Please complete all applicable sections and submit with relevant clinical records, medication lists, and supporting documentation. We serve adults 18 and older, in person and by telehealth. Questions: 763-703-6686.

Section 1: Patient Information

Patient Full Name: _____ Date of Birth: _____

Preferred Name: _____ Gender: _____

Phone: _____ Email: _____

Home Address: _____

Preferred Contact: ☐ Phone ☐ Email ☐ Text

Preferred Language: _____

Emergency Contact Name: _____ Phone: _____

Insurance carrier: _____ Member ID: _____

Preferred pharmacy: _____ Primary care provider: _____

Patient is 18 years of age or older: ☐ Yes ☐ No

Section 2: Referral Source Information

Referring Provider: _____ Credentials: _____

Organization/Practice: _____ Phone: _____

Fax: _____ Email: _____

Referral Date: _____

Referral Source Type: ☐ Primary Care ☐ Psychiatrist ☐ Therapist/Counselor ☐ Hospital ☐ Self-Referral ☐ Other: _____

Section 3: Reason for Referral

Requested Services: ☐ Comprehensive Psychiatric Evaluation ☐ Medication Evaluation ☐ Ongoing Medication Management ☐ Psychiatric Therapy ☐ Medication-Assisted Treatment ☐ Second Opinion ☐ Other: _____

Presenting Symptoms (check all that apply):

☐ Depression/Low Mood ☐ Anxiety/Panic ☐ ADHD ☐ Mood Instability ☐ Bipolar Symptoms ☐ Sleep Disturbances

☐ Trauma/PTSD ☐ OCD ☐ Psychotic Symptoms ☐ Borderline Personality Disorder ☐ Substance Use ☐ Other: _____

Brief Description of Presenting Concerns: _____

Duration: ☐ <1 month ☐ 1–6 months ☐ 6–12 months ☐ >1 year ☐ Unknown

Section 4: Relevant Psychiatric History

Previous Psychiatric Diagnosis(es): _____

Previous Psychiatric Hospitalizations: ☐ Yes ☐ No ☐ Unknown

Previous Outpatient Mental Health Treatment: ☐ Yes ☐ No ☐ Unknown

Previous Psychiatric Medication Trials: _____

Current Psychiatric Medications: _____

Previous Medication Response or Adverse Effects: _____

Current Therapist/Counselor (if applicable): _____

Section 5: Medical and Substance Use History

Relevant Medical Conditions: _____

Current Non-Psychiatric Medications: _____

Known Medication Allergies: _____

Substance Use: ☐ Alcohol ☐ Cannabis ☐ Tobacco/Nicotine ☐ Prescription Misuse ☐ Other ☐ Denies ☐ Unknown

Section 6: Safety and Risk Assessment

Suicidal Ideation: ☐ Yes ☐ No ☐ Unknown

History of Suicide Attempts: ☐ Yes ☐ No ☐ Unknown

Homicidal Ideation: ☐ Yes ☐ No ☐ Unknown

History of Self-Injury: ☐ Yes ☐ No ☐ Unknown

History of Aggression/Violence: ☐ Yes ☐ No ☐ Unknown

Psychosis/Hallucinations: ☐ Yes ☐ No ☐ Unknown

Additional Safety Concerns: _____

Current Risk Status: ☐ No known immediate concerns ☐ Further assessment recommended ☐ Elevated risk ☐ Acute safety concern

Important: This form is not for emergency care. Patients in crisis should be directed to 911, the nearest emergency department, or 988 (call or text). For urgent or elevated-risk referrals, also call the clinic at 763-703-6686 on the same day; do not rely on fax alone.

Section 7: Clinical Documentation to Attach

☐ Recent Primary Care/Medical Notes ☐ Previous Psychiatric Evaluation ☐ Current Medication List

☐ Previous Medication Records ☐ Psychological Testing/ADHD Assessment ☐ Recent Lab Results

☐ Hospital Discharge Summary ☐ Other: _____

Section 8: Referral Priority

☐ Routine Referral ☐ Urgent Referral ☐ Time-Sensitive Evaluation

Preferred Timeframe: _____

Section 9: Consent and Authorization

I acknowledge that the information provided is accurate to the best of my knowledge. Relevant clinical information may be shared with the receiving psychiatric provider for treatment and care coordination, as permitted by applicable privacy laws. Records from other providers may require a separate signed authorization.

Patient Name: _____ Signature: _____ Date: _____

Referring Provider Signature: _____ Date: _____

For Office Use Only

Date Received: _____ Reviewed By: _____

Status: ☐ Accepted ☐ Pending ☐ Declined

Appointment Scheduled: ☐ Yes ☐ No

Appointment Date: _____

Follow-Up Required: ☐ Yes ☐ No

Additional Notes: _____