Psychology Associates
OF CHESTER COUNTY, PC

# Referral for Psychological Services

Date of referral: _____ Referral Contact: _____ Phone: _____

Patient Name: _____ Patient's DOB: _____

Insurance: _____ Is the patient accepting of the referral? ☐ Yes ☐ No

Contact Preference: ☐ Patient will call for appointment

☐ Please call patient/referral source to arrange appointment (Phone: _____)

**Reason for Referral (check all that apply)**

| | | | | |
|---|---|---|---|---|
| **Mood Problems:** | ☐ Anxious/Worried<br>☐ Stressed/ Tense<br>☐ Extreme Reactions | ☐ Depressed/Sad<br>☐ Hopeless/Helpless<br>☐ Feeling "Stuck" | ☐ Mood Swings<br>☐ Manic/Euphoric<br>☐ Low Self-Esteem | ☐ Angry/Irritable<br>☐ Overwhelmed<br>☐ Inappropriate Guilt |
| **Behavior Problems** | ☐ Non-Adherence<br>☐ Substance Abuse | ☐ Unhealthy Eating Habits<br>☐ Unhealthy Sleep Habits | ☐ Communication Skills<br>☐ Interpersonal Problems | ☐ Impulsive Behavior<br>☐ Medication Seeking |
| **Thought Process** | ☐ Insightful<br>☐ Lacks Insight | ☐ Attention Problems<br>☐ Tangential/Circumstantial | ☐ Obsessive<br>☐ Self-Critical | ☐ Bizarre/Unusual<br>☐ Memory Problems |
| **Medical & Health Related** | ☐ Complaints disproportionate to organic pathology<br>☐ Unhealthy Lifestyle<br>☐ Poor Self-Care | ☐ Difficulty coping with/accepting illness<br>☐ Family/relationship stress undermining health/ recovery | ☐ Multiple physical complaints in the absence of physical findings<br>☐ Keeps bringing up complaints already addressed<br>☐ Not making progress despite improved organic status | |
| **Other Issues** | ☐ Work Stress | ☐ Family/Relationship Stress | ☐ Financial Problems | ☐ Bereavement/Loss |
| **Motivation** | ☐ Good | ☐ Fair | ☐ Poor | ☐ Not sure |
| **Supports** | ☐ Good | ☐ Fair | ☐ Poor | ☐ Not sure |

Requested Service: ☐ Individual Therapy ☐ Marital/Family Therapy ☐ Psychological Evaluation/Testing ☐ Risk Assessment

Risk Assessment: ☐ Routine ☐ Urgent (appt. within 48-72 hrs.) ☐ Emergent (appt. needed within 24 hrs.)

Medical Condition(s):_____

_____

Medications: _____

_____

_____

Additional Notes: _____

_____

## Please Fax Referral to 610.873.4715

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