ZIKS
HEALTH SERVICES

REFERRAL FORM

** Please call the clinic: 972-972-4850 to confirm your urgent appointments*

Please complete and/or have the patient answer the questions, as appropriate.
Attach progress notes & relevant labs/imaging reports.

BEHAVIORAL HEALTH
* Psychopharmacology
* Psychotherapy

REFERRAL FAX #: 956-267-1142

A. REFERRING SOURCE Date of referral:				
Facility Name:			Medical Record Number:	
Type of Facility: ☐ Emergency Room	☐ Inpatient	☐ Outpatient	☐ PCP	☐ Other:
Name and title of referring source:				
Phone number:			Fax Number:	
Referring Provider:			Specialty:	
Phone number:			Fax Number:	
B. PATIENT INFORMATION				
Patient Name:			Date of Birth: / /	
Gender: Male ☐ Female ☐				
Language:				
Address:				
Best Contact Phone:	Alternate Phone:		Email:	
C. INSURANCE INFORMATION				
Company:			Policy Holders Name:	
Policy ID#:	Group#:		Insurance phone #:	
D RELEVANT CLINICAL INFORMATION				
Reason for Referral/Presenting Problem: ______				

E. Behavioral Health Issues: Please, indicate the symptoms the person has experienced:

Symptom	Past	Recent	Current	Description of symptom(s)
¤ **Suicidal Ideation/Attempt**	☐	☐	☐	***** If patient experiencing ACTIVE suicidal thoughts with plan & intent to hurt themselves please Call 911 or facilitate the transfer of patient to nearest ER or in -patient psychiatric facility**
☐ Psychosis	☐	☐	☐	☐Command hallucinations ☐Paranoia
☐ Mood Instability	☐	☐	☐	☐Agitation ☐Impulsiveness ☐Self-mutilation behavior ☐Irritability
☐ Depression	☐	☐	☐	☐Low energy ☐Low concentration ☐Little pleasure ☐Fatigue
☐ Anxiety	☐	☐	☐	☐Restlessness ☐Nervousness ☐Panic Attacks ☐Feeling tense
☐ Post-Traumatic Stress	☐	☐	☐	☐Hx of Trauma ☐Avoidance ☐Flash Backs ☐Hypervigilance
☐ Cognitive problems	☐	☐	☐	Dementia: ☐ yes ☐ no
☐ H/O Aggressive Behavior	☐	☐	☐	☐Damaging property ☐Required seclusion/Restraint ☐Homicidal Ideation, Explain:
☐ Patient Taking Lithium	☐	☐	☐	If current or recent: Last Levels: Date:______ Measure Level: ______
☐ Patient Taking Valproic Acid	☐	☐	☐	If current or recent: Last Levels: Date:______ Measure Level: ______
☐ Patient Taking Benzodiazepines	☐	☐	☐	Patient taking any, but not limited to the following: Xanax, Valium, Klonopin, Ativan

Please describe any of the above checked behavior in detail including what, when, precipitant and **how the behavior was stopped**: