



BRIDGES SEATTLE

<https://www.bridgesseattle.com>

Phone number: 206.745.1191 fax number 1.888.467.5306

Referral Form

Date: _____

Referring Provider: _____

Referring Office Phone: _____

PATIENT DEMOGRAPHIC INFORMATION (or attach EHR demographics)

Patients Name: _____

DOB: _____ Phone Number: _____

Physical Address: _____

Guardian Name (if applicable): _____ Guardian Phone Number: _____

Relationship to Patient: _____

INSURANCE INFORMATION (or send EHR demographics)

Primary Insurance Company: _____ Member ID# _____

Group ID# _____ Guarantor Name: _____



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Guarantor DOB: _____ Guarantor relationship to patient: _____

CLINICAL INFORMATION (or attach last relevant note)

Reason for Referral (Check one): ☐ Therapy
☐ Medication Management
☐ Neuropsychological Testing

If you've selected Neuropsychological Testing please include a short note in the space below stating what they're to be tested for, symptomology and how it affects functioning/life.

Diagnosis

Current Psychiatric Diagnosis _____

Relevant Medical Diagnosis _____

Current Psychiatric Treatment

Current Symptoms: _____

Current Suicidal / Homicidal Thoughts? No ☐ Yes ☐

Details: _____

Current Medications (psychiatric or otherwise, please include dose. **Attach list if preferred**):



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