THE GIFT MENTAL HEALTH CLINIC, LLC

REFERRING TO

The Gift Mental Health Clinic, LLC	**Phone: 504-644-2575**	**Fax: 504-504-226-0339**
Practice Name & Address: 3301 Canal Street #1 New Orleans, La 70119		
Please Schedule (select all that apply): Urgent-- Referring physician called _____ ☐ Assessment with LMHP _____ First Available with any LMHP/Psychiatrist		
Referring Provider's Name:	**Phone:**	**Fax:**

TYPE OF REFERRAL

Community Psychiatric Support and Treatment (CPST)
Psychosocial Rehabilitation (PSR)
Crisis Intervention
Independent Living Skills Building
Intensive Outpatient (Substance Abuse)
OTHER _____

PATIE NT INFORMATION

Patient Full Legal Name:		DOB
If patient is under 18 years old – Parent Contact Name:		
Preferred Phone:	Best time to call:	
Special Patient Considerations:		
Patient Insurance Information:		
Patient's Primary Care Provider:	Phone:	Fax:

GENERAL INFORMATION

Reason for Referral (*Clinical Question*):
Comments/Considerations Related to Clinical Question: **Please include recent labs, pertinent imaging reports, medication list, problem list, allergies, and relevant clinical notes. **
Patient aware of reason for referral? ☐ Yes ☐ No: Explain

PROVIDER REFERRAL CONFIRMATION

Referral Accepted? Yes No: Explain	
Appointment Scheduled with:	**Date & Time:**

REFERRAL CONFIRMATION		
	Patient refused scheduling	Patient prefers to contact specialist to schedule at a later date
	Request for additional supporting clinical information (please detail)	
	Person completing confirmation:	**Date of Confirmation:**

PLEASE EMAIL FORM TO: giftreferral@outlook.com