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| Patient Name: | Date of birth: |
| Primary Care Provider: |
| Who referred you to see psychiatry: |
| Why are you being sent to a psychiatric provider:

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|  | Medication Management |  | Therapy/ Counseling/Psychological Evaluation |

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| Medication Allergy:  | Response: |
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| Previous *outpatient* Mental Health or Drug Treatment or Programs? No or Yes (explain) |
| Date(s): | Reason/Treatment: |
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| Previous *hospital stays* forMental Health or Drug Treatment Programs in the past year? No Yes (explain)  |
| Date(s): | Reason/Treatment |
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| Medical History (Check box and explain if applicable): |
|  | Heart disease/Heart attacks |
|  | High blood pressure |
|  | Diabetes |
|  | Thyroid disease |
|  | Stroke  |
|  | Neurological disorders  |
|  | Dementia/ Neurocognitive Disorder |
|  | Stomach/Gastrointestinal disorders |
|  | Lung disease/Respiratory disorders |
|  | Other:  |
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| **Current Medications:** |
| Name of Medication: | Dose and Frequency | Reason for use: |
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| \*\*Please remember to bring all medication in the container given to you by pharmacy to your first appointment. \*\***\*\*It is your responsibility as a patient to give accurate medication information and notify the providers of medication changes at each appointment\*\*** |