Complete and submit to support@mymentalgoal.com

Goal Mind Services Referral Form

Date of Referral: _____

Referral Source

Referring Provider Name_____Agency_____Contact Phone # _____
Is client aware of and agreeable to this referral?_____ Yes _____ No Urgent? ____Yes _____No

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name_____
Address (incl. zip code)_____
Home Phone #_____Cell Phone #____Social Security # ____ DOB __/__/_____Sex _____
Race_____Marital Status ____ Single _____ Married ____Divorced _____
Emergency Contact Name_____Relationship to Patient_____Contact # _____
Primary Care Physician_____Clinic Name_____Phone_____
Current Type of Housing (e.g., group home):_____Veteran ___Yes ___No

CLINICAL INFORMATION

Reason for Referral _____

_____

Diagnosis (*list confirmed if known, if not list suspected*)
Primary Psychiatric Diagnosis _____
Secondary Psychiatric Diagnoses (including substance abuse) _____
Relevant Medical Diagnoses _____
Relevant Social Factors _____

Past Psychiatric History (hx) and Treatment (*please check appropriately*)
Former patient in clinic referred to? # No # Yes, details _____
Hx of violence? # No # Yes, details _____
Hx of suicide attempts? # No # Yes, details _____
Hx of psychiatric hospitalizations? # No # Yes, details _____
Previous symptoms and diagnoses _____

Current Psychiatric Treatment & History
Current Symptoms _____
Current suicidal / homicidal thoughts? # No, # Yes, details _____
Does patient have a current outpatient mental health provider? # No # Yes, details _____
Reason not returning _____
Additional Information _____

_____

Current Psychiatric Medications (*name & dose*, attach list if preferred)

_____

_____

_____

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Additional Screening info

Has high blood pressure issues?
If applicable, Has blood pressure issues controlled by medication?

Current or last BP?

Cardiovascular concerns?

Has severe or unstable thyroid conditions including hyperthyroidism?

Has bipolar disorder?

History of mania?

Has schizophrenic or psychosis?

Do you currently have thoughts of harming yourself? Or, have you attempted suicide within the past month?

Has active substance abuse?

Active treatment for substance use?

Heart rate per minute

Weight in pounds

Previous Psychedelic consumption?

Any active or historical medical concerns?

Anything you'd like your provider to know?

What are your mental health goals?

Signature of Referral Source_____Date / Time _____