

INPATIENT PSYCHIATRIC TREATMENT REFERRAL FORM

Date:

Patient Name:

Date of Birth:

Insurance Plan: (Policy type/member number)

(Please attach patient face sheet with all demographic information)

I am referring the above-named patient/client for **inpatient psychiatric treatment**. Based on clinical presentation and assessment, this patient **requires** inpatient-level care.

The following clinical factors necessitate inpatient psychiatric admission:

- ☐ Active suicidal ideation, plan, or behavior
- ☐ Homicidal ideation or significant risk to others
- ☐ Severe psychiatric symptoms impairing safety or functioning
- ☐ Inability to safely stabilize in an outpatient or community-based setting
- ☐ Other:

Presenting Symptoms/Concerns: (Provide a concise summary of symptoms, diagnosis, and current mental status.)

Pertinent Psychiatric/Medical History: (Include past hospitalizations, medications, substance use history, etc.)

Current Interventions and Limitations: (Outline treatments already in place and why they are insufficient at this time.)

This patient/client meets the medical necessity for inpatient psychiatric care and should be admitted for comprehensive evaluation, stabilization, and treatment in a 24-hour structured setting.

Please contact me directly with any questions or to coordinate the admission process.

Sincerely,

Provider Full Name, Credentials:

Practice Name/referring agency:

Phone:

Fax:

Email:

NPI #: (if relevant)