SUNRISE THERAPY SERVICES, LLC

3715 MAIN STREET SUITE 410
BRIDGEPORT, CT 06606

Referral Form

Referral Source Information:

Person Making Referral: _____ **Date:** _____

Referral Organization: SUNRISE THERAPY SERVICES, LLC **Phone #:** 203-612-4300

Office Contact Person: _____ **Fax #:** 203-612-4301

Patient Information:

Patient Name: _____ **Date of Birth:** _____

Parent/Guardian (if applicable): _____ **Phone #:** (____) _____

Primary Insurance: _____ **Subscriber Name:** _____

Patient Referred for: (check one or more boxes below)

☐ **Psychotherapy/Counseling** – *Depression, Anxiety, Substance abuse, Insomnia, Behavior change (smoking cessation, healthy eating, etc.), Personality disorder, Relationship issues, Stress management, etc.*
☐ **Psychological Testing** – *ADHD, Learning disability, Autism, Brain injury, Dementia, Pre-surgical testing, etc.*
☐ **Psychiatry** – *Medication evaluation and/or management*
☐ **Substance Abuse** – *Assessment to determine level of care needed (Outpatient, IOP, PHP, Sub-Acute Detox)*

Please explain: _____

Patient's preference for clinician, if any (gender, age)**:** _____

PHQ-9 Score (If available): _____

Patient's Release of Information: ***I authorize this referral source to share this form with*** **SRTS** ***for the purpose of discussing and scheduling my appointment. An additional release of information will be required to discuss treatment.***

Patient signature: _____ Date: _____

☐ Please check box if patient provided verbal consent.

Please fax form back to referral source within 72 hours of request.

Referral Status: ☐ Appointment Scheduled: Date: _____

Clinic: _____ Clinician: _____

☐ Patient unable/declined (circle) to schedule: _____

☐ Not scheduled due to: _____

completing this form: _____