REFERRAL FOR OUTPATIENT PSYCHIATRIC SERVICES TO GROWTH OPPORTUNITY CENTER

<table>
<tr><td>Patient Name:</td><td>DOB:</td><td>Sex:</td></tr>
<tr><td>How Long have you been treating this patient?</td><td colspan="2"></td></tr>
<tr><td>For Children Under 18:</td><td colspan="2">Marital Status of Parents:
○ Married
○ Separated
○ Divorced
○ Never Married</td></tr>
<tr><td>Patient/Guardian 1 (if applicable):

Name:

Address (if different from patient):

Phone Number:</td><td colspan="2">Parent/Guardian 2 if applicable:

Name:

Address (if different from patient):

Phone Number:</td></tr>
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Gender Identity:
Preferred Pronouns:

Please list any working diagnoses:
Presenting Concern/Chief Complaint (include onset, current symptoms, frequency, intensity, duration):

Acute/Chronic Medical Conditions: **Relevant Stressors (Include Actual or Suspected Abuse, Traumatic Experiences):**
Please describe relevant treatment factors including treatment modality (e.g. CBT, psychodynamic, family, etc), frequency of sessions, compliance with treatment, who attends sessions other than identified patient:

Current Medications

Condition (Medical and/or psychiatric)	**Medication**	**Dosage/Frequency**	**Date Started**

Alcohol and Drug Assessment (Please do not leave blank)					
Substance	**Age of 1st Use**	**Use Years of Continuous**	**Days Use in Last 30 Days**	**Frequency**	**Don't Know/No Information**
Tobacco					
Alcohol					
Crack/Cocaine					
Marijuana (specified if prescribed)					
Heroin/Other Opiates (specify)					
PCP					
Benzodiazepines (specify is prescribed)					
Other (specify):					

Past Behavioral Health/Substance Abuse Treatment History:

Type (Outpatient/Inpatient)	**Facility or Provider**	**Dates and/or Duration of Treatment**	**Reason Terminated**

Suicidal/Homicidal Risk 0 = no 1= yes 2 = suspected 3 = unknown 4 = past

Risk Factor	**0-4**	**Notes**
Ideation		
Intent		
Plan		
History		
Other Self harm		
Homicidal		

Ideation/Intent/Plan		

Family History of Behavioral Health/ Substance Abuse Diagnoses:

Relationship	Behavioral Health	Substance Abuse

Assessment of Strengths (check all that apply)

Maturity Intelligence Open Minded Honesty Resiliency Self-Confidence/Good Self-Esteem Patience	Strong Religious/Community Connection Effective Communication Skills Stable Interpersonal Relationships	Hopefulness Stable Employment Effective Coping Skills Attendance to 12 Step Meetings Effective Financial Management Skills Other:

Please include any other relevant information:

Referring Clinician Information

Clinician's Name:
Work Address:

Phone Number:	
Email Address:	**Date Submitted:**

Please Complete and Submit to gocenter@hushmail.com or Fax to 215-938-7607.

GOC 928 Jaymor Road; Suite B-150; Southampton, PA 18966; 215-947-8654; option 5