Community Healthcare System

ST. CATHERINE Hospital

Referral Form

Specialty Requested:

☐ Intensive Outpatient Program ☐ Electro Convulsive Therapy

Referring Provider Information

Referring Provider Name		Date *(mm-dd-yyyy)*
Practice Name	Referring Provider Email	
Office Address		City
State		Zip Code
Phone	Fax	Primary Care Provider

Patient Information

Patient Name		Birth Date *(mm-dd-yyyy)*
Patient Email (optional)	Sex Assigned at Birth ☐ Male ☐ Female ☐ Choose not to disclose	
Address		City
State	Zip Code	Country
Home Phone	Alternate Phone ☐ Mobile ☐ Work ☐ Other	
Maiden Name (optional)	Spouse First Name (optional)	
Patient Insurance Information	Does the patient need an interpreter? ☐ Yes ☐ No	If "Yes," what language?

Appointment Request – Please include the following documents with referral form.

Indication or Diagnosis

Please submit:

- Psychiatric Evaluation
- Biopsychosocial Assessment
- Medication List
- Copy of insurance card
- Copy of State ID card
- Any other pertinent information

Please fax all requested documents to:

Fax: (219) 703-6512 Phone: (219) 392-7660

Thank you for referring your patient to St. Catherine Hospital.