EaseCare
EASE OF MIND

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name □ Last □ First	DOB *(dd-Mon-yyyy)*
PHN	ULI □ Same as PHN / MRN
Administrative Gender □ Male □ Female □ Non-binary/Prefer not to disclose (X)	

Mental Health Referral

Fax Number: 855-918-3569

Date *(dd/Mon/yyyy)*	Refer to: □ Mental Health Physician	
Patient Address		Phone
Referring Provider/Source		Phone
Referring Provider Address		Fax
Family Physician		
Legal Guardian Name	Phone	Relationship

Who has been informed of the reason for this referral? □ Patient □ Guardian □ Patient and Guardian

Special Considerations □ Interpreter required □ Physical limitations
□ Social / Psychological □ Economic Details: _____

Referral Information

Reason for referral

Type of Request	□ Advice	□ Consult	
Priority of Referral	□ Routine	□ Urgent	□ Emergent
Patient's Current Status	□ Stable	□ Worsening	

Completed By

Name	Signature	Designation	Date *(dd/Mon/yyyy)*