CULLMAN REGIONAL

Turning Point Health Center
Tyler Byrd, DO William B. Tennant, MD
1948 Alabama Highway 157, POB 1, Suite 360
Cullman, AL 35058
Phone: (256) 735-5570 **FAX: (256) 735-5571**

PSYCHIATRY REFERRAL FORM

Patient's Name: _____

DOB: _____ Phone#: _____ Cell#: _____

Height: _____ Weight: _____

Address: _____

Current Type of Housing (i.e., group home): _____ Veteran ☐ YES ☐ No

Potential Transportation Issues? No Yes, explain: _____

Insurance Carrier: _____

Policy #: _____

Referral authorization # if required _____

Please include clinical documentation such as lab work, clinic notes, if available.

Reason for referral _____

INDICATIONS (circle all that apply)

Suicidal thoughts	Sadness	Confusion
Extreme mood changes	Excessive fear, worry or guilt	Sex drive changes
Low energy/Problems sleeping	Delusions/ Paranoia / Hallucinations	Excessive anger/violence
Inability to cope with daily stress	Changes in eating habits	
Trouble understanding or relating to situations/people		

Other: _____

If child: IEP or education plan in place? Y/N Past psychological testing? Y/N

Past Psychiatric Treatment

History of violence History of suicide History of psychiatric hospitalizations

Current Medication List: _____

ORDERING PROVIDER

Physician: _____

Phone #: _____ Fax #: _____

Appointment Date/Time: _____ Patient notified on: _____

Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures