Rise Up Mental Health Care ~ #7 Rosemar Circle Parkersburg WV, 26104

Phone 304-422-7999 Fax 681-661-0257

Date of Referral: ____/_____/_____

Referring Physician: _____ Practice Name_____

Phone # _____ Fax# _____

Address_____

Reason For Referral: _____

Patient Information

Name (Last)_____ (First)_____(MI)____

DOB:____/_____/_____ Contact #_____ Gender_____

Address_____

Emergency Contact_____ Emergency Contact #_____

Patient Insurance Information

Insurance Co. Name_____

Policy ID #: _____ Group #: _____

Subscriber's Name_____ DOB: ____/____/_____ SSN:_____

Please attach a copy of card

Medical History

Previous Treatment History:_____

Current Prescribed Medications: _____

Psychiatric Diagnosis: ___ Anxiety ____ Depression _____PTSD _____Bipolar _____ ADHD

____ Sleep Disorder ____ OCD _____Schizophrenia _____Other

History of Suicide Attempts: _____

History of Psychiatric Hospitalizations: _____

Medical Concerns: ____Diabetes ____COPD _____HTN _____ Seizures

____ Asthma ____ Pregnant (current) _____ Cardiovascular

_____Hepatitis A/B/C _____ Cancer _____ Other

Substance Use History

Substance	Last Use	Route of Use	Frequency	Prescribed
Alcohol				NA
Benzodiazepine				
Cannabis/Marijuana				
Cocaine				NA
Methamphetamine				NA
Opiates				
Tobacco				NA
Stimulants				
Hallucinogens				NA
Other				

Thank you for your referral to Rise Up Mental Health Care. Please fill out all parts of this document. Missing information may delay treatment or scheduling.

Questions or Concerns: Please feel free to reach out to our office at 304-422-7999