Genesis Perinatal Support & Counseling

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PROFESSIONAL REFERRAL FORM

Thank you for this referral. Upon receipt, we will review to determine whether the client is a good fit for our practice and do our best to connect them with the right provider within 2–5 business days. For urgent concerns, please contact our office directly by phone or fax.

Important — Substance Use History:
Under federal law (42 CFR Part 2), any disclosure of substance use history requires the client's signed written consent prior to sending this form. Please ensure that consent is obtained before including such information.

1. REFERRING PROVIDER INFORMATION

Provider Name *

Credentials / Specialty *

Practice / Organization *

NPI Number

Phone *

Fax

Email *

2. CLIENT INFORMATION

Client First Name *

Client Last Name *

Date of Birth (MM/DD/YYYY) *

Preferred Pronouns

She/Her / He/Him / They/Them / Other

Client Phone *

Client Email

Primary Language

Preferred Contact Method

- ☐ Phone call
- ☐ Text
- ☐ Email
- ☐ Patient portal

3. CLINICAL INFORMATION

Perinatal Stage *

Preconception / 1st Tri / 2nd Tri / 3rd Tri / PP 0-6mo / PP 6-12mo ...

Due Date or Delivery Date (MM/DD/YYYY)

Presenting Concerns (check all that apply)

- ☐ Perinatal depression
- ☐ Perinatal anxiety
- ☐ Perinatal OCD
- ☐ Birth trauma / PTSD
- ☐ Perinatal loss
- ☐ Fear of childbirth
- ☐ Relationship concerns
- ☐ Adjustment difficulties
- ☐ Pregnancy/infant loss
- ☐ Other (describe below)

If "Other" checked, please describe

Diagnosis Code(s) if applicable

Current Medications

Previous Mental Health Treatment?

None / Therapy only / Medication only / Both / Inpatient/IOP / Unknown

Safety Concerns / Risk Factors

None / Passive SI / Active SI — call first / Self-harm hx / DV …

4. INSURANCE INFORMATION

Basic info only — additional details will be collected at intake.

Insurance Company

Name of Insured Person (if different from client)

5. REASON FOR REFERRAL

Urgency of Referral *

Routine (2–4 wks) / Soon (1–2 wks) / Urgent (few days) …

Primary Reason for Referral — clinical context, relevant history, presenting symptoms *

Additional Notes — language needs, cultural considerations, scheduling constraints, other

AUTHORIZATION & CONSENT

By signing below, the referring provider confirms that the client has been informed of this referral and consents to the sharing of this information with Genesis Perinatal Support & Counseling for care coordination purposes, consistent with HIPAA Treatment, Payment & Operations (TPO) provisions.

Provider Signature (print or type full name) *

Date (MM/DD/YYYY) *