OUTPATIENT CARE REFERRAL FORM

This form is a referral for The Brookline Center Psychiatry Department. This form is only to be completed by a licensed provider on behalf of a client.

Please complete to the best of your ability. If you are having any difficulties we can be reached at intake@brooklinecenter.org or (617) 860-2084.

How did you learn about our Center? _____

Does your client have knowledge of this referral? Have they provided their consent?

◯ Yes ◯ No

Date:

Clinician Information

Name:_____

Phone: _____ Email: _____

Licensure: _____

Name & Address of Practice:

_____

Client Information:

Legal First & Last Name:_____

Preferred Name (if different):_____

Sex (as stated on Insurance):_____

Date of Birth: _____

Phone Number:_____

Email: _____

Basic Clinical Information

How long has the client been established in care with you?

Reason for Referral:

Please note: The Brookline Center Intake team will outreach your client with a release of information. Once received, they will contact you, the referring provider, to set up an intake call (15 mins). All referrals will be reviewed to ensure we can provide the most appropriate and effective care.