Farmingdale State College
State University of New York

Mental Health Referral Letter

TO THE PRACTITIONER: Please complete both pages of this form. If you have any questions regarding this form, please contact us at 631-420-2006. Thank you for your cooperation.

Name : _____
Last First Middle

Date if Birth _____ **RAM ID #: R** _____ -_____ -_____

Practitioner Name and Credentials: _____

Practitioner Address: _____
Number Street Apt

_____
Town State Zip Code

Practitioner Phone: _____

Practitioner Type: ☐ **Psychiatrist** ☐ **Psychologist** ☐ **Social Worker** ☐ **Mental Health Counselor**

☐ **Other (Please specify)** _____

Patient Diagnosis (DSM Code and Name, with Specifiers) _____

_____

Last GAF and Date: _____

First Date Seen: _____ **Last Date Seen:** _____

Do you plan on continuing treatment with this patient? ☐ **Yes** ☐ **No**

Does the patient have a history of suicidal or other self-harming behavior or ideation? ☐ **Yes** ☐ **No**

If yes, please give details regarding number, dates, and types of incidents, their duration and resolution:

_____

_____

Does the patient have a history of ideation or behavior involving harm to others? ☐ **Yes** ☐ **No**

If yes, please give details regarding number, dates, and types of incidents, their duration and resolution:

_____

_____

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Has the patient been hospitalized for psychiatric reasons? ☐ **Yes** ☐ **No**

If yes, please give details regarding number, dates, and types of incidents, their duration and resolution:

_____

_____

Has the patient been prescribed medication by you or any other practitioner? ☐ **Yes** ☐ **No**

If yes:	**Medication**	**Dose**
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Is the patient being seen by another mental health professional? ☐ **Yes** ☐ **No**

If yes, please provide that practitioner's name and contact information below:

Name: _____

Address: _____
Number Street Apt

_____
Town State Zip Code

Phone: _____

Practitioner Signature _____ **Date:** _____

Practitioner Name and Credentials: _____
Please Print

Please Return Form to:

Campus Mental Health - Sinclair Hall
2350 Broadhollow Road
Farmingdale, New York 11735

Phone: 631-420-2006
Fax: 631-420-2089