Print

Physician Order

Saint Luke's Health System
Saint Luke's Physician Group

Outpatient Referral (Crittenton)

Crittenton Outpatient Clinic
10918 Elm Ave, Ste 102
Kansas City, MO 64134
816–767–4346
816–251–6367 (Fax)

Only completed referrals will be processed **Fax completed form and records to 816-251-6367**

Date of Request:_____ Parental Custody? ***(If No, attach custody paperwork)*** ☐ Yes ☐ No

Patient Name: _____ DOB: _____

Home Address: _____ Phone Number: _____

Insurance Plan Name ***(attach copy of cards)***: _____

Subscriber Name and DOB *(if different from patient)*:_____

Member/Policy ID: _____ Group Number: _____

Parent/Guardian Name: _____

Address *(if different from patient)*: _____

Phone Number *(if different from patient)*: _____

Case Manager Name *(if applicable)*: _____ Phone Number:_____

Diagnosis / Reason for Referral: _____

Has this patient been established, or is currently established, with a psychiatrist? ☐ Yes ☐ No

If yes, why was that discontinued? _____

Services requested: (Please mark all that apply)

☐ Psychiatric / Medication Management ☐ Psychological Testing (one-time service)

☐ Psychotherapy / Talk Therapy ☐ Autism Testing (one-time service)

☐ Is this service court ordered? (attach copy of court order) ☐ Yes ☐ No

Briefly summarize the following:

Presenting problem including relevant background information and history (if any) of Children's Division Involvement:

_____

_____

Summary of treatment goals and expected outcomes of intervention for this family/child:

_____

_____

REFERRING PROVIDER INFORMATION

Ordering Provider *(please print)*: _____ Contact Phone: _____

WHAT WE NEED FROM YOU BEFORE WE CAN SCHEDULE YOUR PATIENT:

☐ Completed referral form
☐ Copy of insurance card
☐ Previous mental health records including IEP/504
☐ Current medications and past psychotropic medications that have been tried

☐ Interpreter needed? ☐ Yes ☐ No Language:_____

Patient Label: