Mokscare New Patient Referral, Consent and Authorization Form

Referral for Psychiatric Services

Submit referral via one of the following:

FAX: 913-543-4444 / EMAIL: admin@mokscare.com

Facility Name: _____ Facility Phone: _____
Date of Referral: _____ Referring Staff Name: _____ Position: _____
Resident Name: _____ Date of Birth: _____

The following are required to process your referral promptly:

- Facesheet
- Physician Orders
- A copy of Insurance card (front and back)
- Signatures for consent

Reason for Referral Checklist (check all that apply):

☐Psychotropics - Resident currently on or has past history of psychotropic medication use (medication management)
☐Psychosocial Status Change (i.e., death of family member, decreased socialization, etc.)
☐Psychiatric Diagnosis - Past or current history of psychiatric diagnosis and/or hospitalization
☐Resistance to Care and/or refusal of care or participation in treatment
☐Mental Status issues/change (please explain below - suicidal ideation, cognition issues, sadness, anxiousness)
☐Medical Diagnosis that requires adjunctive behavioral care (weight loss secondary to diabetes, chronic pain, etc.)
☐Behavioral issue (please explain below) Family Issues/Conflict
☐Adjustment Difficulties to current living environment Discharge Difficulties due to Psychiatric Issues
☐Adverse Status Change in nutrition, activity participation, vegetative functions, sleep.
☐Other: