Wellspace Referral Form

Please download this form before filling it out, and type or print clearly.

Please fax to **617.855.3820**, Attn: Steve Fedele, CPS

Date: _____

Name: _____ Phone: _____ Email:_____

Address: _____

Age: _____ Date of Birth: _____

Discharge Date if Applicable: _____

Demographic Information (Please note, this section is optional)

Gender: _____ Race: _____ Ethnicity: _____

Person filling out form, if other than patient: _____

Phone: _____ Email: _____

Relationship to patient: _____

Organization or Provider Company (if applicable): _____

Emergency Contact: _____ Phone: _____

2nd Emergency Contact: _____ Phone: _____

Please only list people that you would be comfortable having contacted if an emergency arises.

Has the patient been given a psychiatric diagnosis? If so please list:

_____

_____

Please describe any symptoms from this diagnosis that the patient struggles with:

_____

_____

_____

Does the patient take any medication(s)? If so, please list:

_____

_____

_____

What kind of mental health care if any does the patient currently receive?

_____

_____

Does the patient have any history of substance misuse? If so, please describe.

_____

_____

Does the patient have any medical problems? Including allergens to any foods.

_____

_____

_____

Does the patient live alone, with family, or other? Please describe.

_____

_____

How involved are family or friends? Does the patient have other supports in the community?

_____

_____

Please return the completed form by postal mail or fax to:

McLean Hospital
Attn: Steve Fedele, Wellspace Program Coordinator
115 Mill Street, Mailstop 343
Belmont, MA 02478

Fax: 617.855.3820

With any questions, please contact Steve Fedele, CPS, at 617.855.4214 or sfedele@partners.org