Root & Bloom Therapy

Patient Referral

Fax to 248-617-1268 · Attn: Intake

Phone 248-301-6455 · hello@rootandbloom.net · 1955 W Hamlin Rd, Suite 101, Rochester Hills, MI 48309

Type in the fields (or print and write), then fax with any records. Prefer to submit online? Use refer.rootandbloom.net with your office code.

1 REFERRING PROVIDER

Provider name and credentials *

Practice *

Phone *

Fax

Email

NPI

Send updates about this patient by

☐ Fax ☐ Email ☐ Phone ☐ No updates needed

2 PATIENT

Patient name *

Date of birth (MM/DD/YYYY) *

Phone *

Email

Parent or guardian (if under 18)

Relationship

Guardian phone

Insurance *

Member ID

Preferred language / interpreter needed

OK to leave a voicemail? ☐ Yes ☐ No

3 REASON FOR REFERRAL

☐ Anxiety	☐ Depression	☐ Stress	☐ Grief / loss	☐ Trauma / PTSD
☐ Relationship issues	☐ Family conflict	☐ Life transitions	☐ Pregnancy & postpartum	☐ Women's issues
☐ Self-esteem	☐ Anger	☐ OCD	☐ ADHD	☐ Work / school stress

Other concern

Reason for referral: what you're seeing and what you hope therapy will help with *

Diagnosis or ICD-10 code

Preferred therapist (if any)

Session preference

☐ Office ☐ Virtual ☐ Either

4 URGENCY & SAFETY

How soon should the patient be seen? * ☐ Routine (next few weeks) ☐ Soon (about a week) ☐ Urgent (1–2 business days)

Current suicidal thoughts, self-harm, or risk of harm to others? * ☐ No ☐ Yes ☐ Unknown *If yes, please also call us.*

Psychiatric hospitalization in the past year? ☐ No ☐ Yes ☐ Unknown

Current medications (especially psychiatric)

5 CONSENT

☐ The patient (or parent/guardian) knows about this referral and agreed to be contacted by Root & Bloom Therapy. *

☐ The patient also agreed we may send updates about their care to the referring office.

Referring provider signature

Date