HIGHPOINT HEALTH

Psych Services: Medical Necessity Form

Patient's Name: _____

Social Worker or Nurse: Please mark the reason(s) the Patient is being referred to HighPoint:

Depressive Sxs

- ☐ Sadness
- ☐ Grief
- ☐ Irritability
- ☐ Insomnia
- ☐ Excessive Sleep
- ☐ Fatigue
- ☐ Poor Appetite
- ☐ Inactivity
- ☐ Tearfulness
- ☐ Low Motivation
- ☐ Hopelessness
- ☐ Talk of Death
- ☐ Suicidal Ideas
- ☐ Suicidal Gestures

Bipolar Sxs

- ☐ Mood Swings
- ☐ Excessive Energy
- ☐ Hyperactivity
- ☐ Euphoria
- ☐ Sleeplessness

Anxiety Sxs

- ☐ Nervousness
- ☐ Worry
- ☐ Excessive Fears
- ☐ Nightmares
- ☐ Physical Sxs
- ☐ Obsessive Thoughts
- ☐ Compulsive Behaviors

Psychotic Sxs

- ☐ Hearing Voices
- ☐ Seeing Things
- ☐ Paranoia
- ☐ Surreal Experience
- ☐ Poor Hygiene

Other Sxs

- ☐ Agitation
- ☐ Resistance to Care
- ☐ Verbal Aggression
- ☐ Combativeness
- ☐ Med Noncompliance
- ☐ Language Impairment
- ☐ Altered Mental State

Other (Describe Below)

Physician (or NP/PA): Based on my professional opinion, the referral for psychotherapy and/or psychiatric services (as indicated on the Consent Form) is medically necessary. Such services are approved and ordered.

_____	_____	_____
Name of Physician (or NP/PA)	Signature	Date
PLEASE PRINT CLEARLY		

Items needed for a Complete Referral:
Consent Form
Medical Necessity Form (or a Medical Order)
Patient's Face Sheet

Send Items To:
eMail: Referrals@HighPoint.health
Fax: (844) PSYCH-FX
(844) 779-2439

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