



PERSONAL DYNAMICS

A registered trade name of
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Counseling Referral Form

Date _____

Patient Name _____

Referring Healthcare Professional: _____

Symptoms. I am referring the above named patient because of the following symptoms or conditions:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Depression/Bipolar | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Psychosomatic Sx |
| <input type="checkbox"/> Depersonalization/Derealization | <input type="checkbox"/> Obsessive-Compulsive Sx | <input type="checkbox"/> Psychosis | |
| <input type="checkbox"/> Anger Issues/Type A Behaviors | <input type="checkbox"/> Grief & Loss | <input type="checkbox"/> Hypochondriasis | |
| <input type="checkbox"/> Occupational/Educational Distress | <input type="checkbox"/> Family Conflict | <input type="checkbox"/> Marital Conflict | |
| <input type="checkbox"/> Migraine/Tension Headaches | <input type="checkbox"/> TMJ/TMD | <input type="checkbox"/> Chronic Health Condition | |
| <input type="checkbox"/> Essential Hypertension | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Insomnia | |
| <input type="checkbox"/> Generalized "Stress" (chronic over-arousal of the Autonomic Nervous System) | | | |
| <input type="checkbox"/> Other (please specify) _____ | | | |

Modes of Therapy. Please consider the following types of therapy for these symptoms:

- Individual Marital/Conjoint Family
- Any therapies that will reduce or eliminate the above symptoms

Medication Management. My preferences regarding psychotropic medications are:

- I am currently prescribing psychotropic medications for this patient.
- Please refer the patient back to me for any psychotropic medications.
- Please refer the patient back to me for psychotropic medications as long as they are not suicidal, psychotic or in severe distress.
- Please refer the patient to a psychiatrist for psychotropic medications.
- Other (please specify) _____

Comments:

When completed you can fax this form to (480) 813-2590 or
send it with the patient. - Thank You for the referral!