

**SUZANNE M. RUTTI, MSW, LISW-S**

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**Professional Referral Form**

**Client Name:** \_\_\_\_\_  
**Guardian (if applicable)** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_  
**Email:** \_\_\_\_\_  
**Best way to contact:** \_\_\_\_\_  
**Gender:** \_\_\_\_\_

**Professional Name:** \_\_\_\_\_  
**Agency:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_  
**Relationship to Client:** \_\_\_\_\_  
**Email:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_

**Client Insurance:** \_\_\_\_\_

**PCP:** \_\_\_\_\_

**Diagnosis:**

**Primary area of focus:** \_\_\_\_\_

**Psychosocial factors:** \_\_\_\_\_

**Medical conditions (if not primary area of focus)** \_\_\_\_\_

**Clinical narrative (if needed):** \_\_\_\_\_

**Current medications:** \_\_\_\_\_

**Safety concerns:**  Suicidal ideation  Homicidal ideation  History of suicide attempt  Self-harm

**Treatment concerns:**  Currently hospitalized  Recently discharged  Substance use  Psychosis

**Reason for referral:** \_\_\_\_\_

**Other current/past providers:** \_\_\_\_\_

**Client strengths/resources:** \_\_\_\_\_

**Special needs/considerations:** \_\_\_\_\_

Client to contact Suzi  Suzi to contact client

**To Be Completed by Receiving Provider**

**Appointment Type:**  Immediate  Urgent  Routine

**Action:**  Appointment offered: \_\_\_\_\_

Appointment scheduled: \_\_\_\_\_

Other referrals provided: \_\_\_\_\_

Unable to reach client: \_\_\_\_\_

Left message with client: \_\_\_\_\_

No response from client: \_\_\_\_\_