THE FORT CHRISTIAN PSYCHIATRIC CENTER / SHAW WENDI FORTUCHANG, MD, PC
SHAW WENDI FORTUCHANG, M.D., FAPA
BOARD-CERTIFIED IN ADULT, CHILD & ADOLESCENT AND FORENSIC PSYCHIATRY
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CHILD & ADOLESCENT REFERRAL FORM

The Fort Christian Psychiatric Center does NOT accept insurance
We cannot accept patients on Medicare / Medicaid
Please complete this form in its ENTIRETY

Provider Information

Name of Referring MD/Therapist: Title:
Name of Practice:
Address:
Office #: Fax #: Email:

Is the referred patient aware that our practice is overtly Christian and that Dr. Fortuchang uses The Word of God as the foundation for treatment? Yes ___ No ___

Information Regarding the Referred

Briefly describe the specific reasons for this referral:

Is the referred currently in psychotherapy? Yes ___ No ___ **(If YES, please attach a treatment summary)**

Has the referred ever received inpatient psychiatric treatment? Yes ___ No ___
Is there a history of suicide attempt(s)? Yes ___ No ___

Name of the referred: First: MI: Last:
DOB:
Address:
Home #: Mobile # Email:
Names of Parents:
Are biological parents married? Yes ___ No ___ If NO, then who is the custodial parent?
Name of school: Grade:

Please check the following applicable area(s) of concern:

ADHD ___ Mood Disorder (Depressive D/O, Bipolar D/O) ___
Anxiety D/O ___ Obsessive Compulsive D/O ___
Autism Spectrum D/O ___ Panic D/O (Panic Attacks) ___
Behavioral D/O ___ Personality D/O ___
Eating D/O ___ Psychotic D/O (AVH/Obsessions/Delusions/Schizophrenia) ___
History of Violence/Dangerousness/Homicidal Ideation ___ PTSD ___
Intellectual Disabilities ___ Substance Use D/O ___
Learning D/O ___ Self-Injurious Behaviors ___
Legal History ___ Suicidality/Suicidal Ideation ___
Medical Conditions ___ IEP/504 PLAN ___ Sleep problems ___

Please comment further on the item(s) checked above:

Please list ALL prescribed medication: