BENSON-HENRY INSTITUTE FOR MIND BODY MEDICINE AT MASSACHUSETTS GENERAL HOSPITAL
MGH 1811

151 Merrimac St., 4th Floor, Boston, MA 02114
Tel: 617.643.6090
Fax: 617.643.6077

Affix Patient Label Here or Note MGH Unit #

PATIENT INFORMATION (NOTE: THIS FORM IS NOT FOR INSURANCE PURPOSES. PATIENTS WITH MANAGED CARE PLANS WILL REQUIRE AN INSURANCE REFERRAL FROM THEIR PCP).

Patient Contact Information

Name: _____

Daytime Phone: _____

Date of Birth: _____

Male ☐ Female ☐

Evening Phone: _____

Primary Reason for Referral (See attached service descriptions)

Physician Consultation: ☐ **OR**

(Do not check if referring directly into a program)

Mind Body Programs: (Check one)

151 Merrimac St, 4th Floor, Boston

- ☐ Stress Management And Resiliency Training (for medical symptoms)
- ☐ Health and Fertility
- ☐ Mind Body Program For Women
- ☐ Successful Aging
- ☐ Program for Cancer

Clinical Information (Check all major conditions that apply)

If Partners HealthCare Provider: attach LMR note or enter recent date of service: _____

- ☐ Anxiety/Depression
- ☐ Cancer/Side Effects of Treatment
- ☐ Cardiovascular Disease
- ☐ Chronic Pain Syndromes/ Fibromyalgia
- ☐ Diabetes
- ☐ Hypertension
- ☐ Infertility
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Syndrome
- ☐ Peri/Menopause
- ☐ Osteoarthritis
- ☐ TMJ Pain

☐ Other major medical problems: _____

Current Medications: _____

Psychiatric history: _____

Other considerations that may restrict participation: ☐ No ☐ Yes (please explain) _____

Referring Provider

Name: _____ **Patient's PCP?** ☐ **Yes** ☐ **No**

Practice Name: _____ **Hospital Affiliation:** _____

Address: _____

Phone: _____ **Fax:** _____

Provider Email: _____

Non Partners Provider Certification: I have received authorization from the patient above to release this information and permit the Benson-Henry Institute staff to contact him/her for follow-up.

Provider Signature: _____

PLEASE FAX TO (617) 643-6077