Referral Letter Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · August 2026

A mental health referral letter is a signed, dated request from one clinician to another to assess or treat a named client. It states the referral question, relevant history, current medications, symptoms and measures, risk status, and what the referrer keeps doing while care continues. GPs, therapists, psychologists, and psychiatrists exchange one whenever care crosses providers; most run 150 to 500 words.

Header, addressee, and identifiers the particulars payment checks
Do: date, your name, credentials, practice details (AU: provider number; US plan referrals: NPI), client name, DOB, and contact.
Pitfall: assuming you must name a clinician. Australia expressly allows a generic address; Ontario accepts a clinic name.

Referral question one or two sentences, placed first
Do: what you are asking the receiver to do (assess and advise, evaluate for medication, deliver therapy), for whom, and why now.
Pitfall: "please assess" with no answerable question; one audit found more than 40% of mental health referrals not accepted.

Relevant history and medications what changes the receiver's decision
Do: working diagnosis, treatment to date and response, prior episodes, medical history, current medications with doses.
Pitfall: omitting the medication list; Better Access requires it, and a psychiatrist evaluating for medication looks for it first.

Current symptoms and measures dated scores beat adjectives
Do: the presentation now, dated scores (PHQ-9, GAD-7, K10, DASS-21), and the impact on work, study, or relationships.
Pitfall: adjectives alone; "significant distress" gives the receiver nothing to triage on or retest against.

Risk status one explicit line either way
Do: state risk plainly, present or absent, with when you last assessed it.
Pitfall: silence; the receiver sets urgency from this line, and a letter that skips risk forces a re-triage from nothing.

Your ongoing role a referral is not a transfer
Do: what continues with you: session frequency, focus, who the client contacts between appointments, how to coordinate.
Pitfall: an unstated role reads as a transfer of care; the receiver may assume they now hold the whole case.

Urgency, sessions, attachments, and signature the fields rebates hang on
Do: priority and timeframe, sessions requested (AU: six assumed), MHTP or PAMP status, attachments; sign and date.
Pitfall: unsigned or undated letters fail Australian rules; a missing referrer NPI denies US plan claims (CARC 183, N286).

Before you send

- [ ] Referral question stated first and answerable in one visit
- [ ] History filtered to what changes the receiver's decision
- [ ] Current medications listed with doses
- [ ] Scores dated and trended for the receiver to retest
- [ ] Risk stated either way, with method and recency
- [ ] Ongoing role, attachments, signature, and date all present

Drafting with AI

Bring a few bullets, a dictation, or the relevant chart notes; convention fixes the order: referral question first, then history, medications, measures, risk status, and your ongoing role.

"Draft a referral letter to a psychiatrist for medication evaluation: recurrent major depression, 14 CBT sessions with gains plateaued, PHQ-9 14, no prior medication trials, low risk, weekly therapy continues: …"

Never paste patient-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

150 to 500 words	10 to 20 min by hand	Asks a defined task	Receiver · record · payer
a single page	clinical team estimate	while your care continues	who reads it

Full guide, sample letter, and compliance notes:
bastiongpt.com/template/referral-letter

BastionGPT drafts complete referral letters from your notes. Free 7-day trial.

Mental Health Referral Letter Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Date: | From (referring clinician): | Credentials:

Practice address and phone / provider no. (AU) / NPI (US plan referrals):

To (a named clinician, a practice, or "Dear colleague"):

Client: | DOB: | Phone:

Referral question

Placed first: what you are asking the receiver to do (assess and advise, evaluate for medication, deliver a course of therapy), for whom, and why now

Relevant history and medications

Working diagnosis · treatment to date and response · prior episodes · relevant medical history · current medications with doses (required on Better Access referrals)

Current symptoms and measures

The presentation now · functional impact on work, study, or relationships · dated scores where you have them (PHQ-9, GAD-7, K10, DASS-21)

Risk status (state it either way, with the date last assessed):

My ongoing role (session frequency; contact between appointments; coordination):

Priority: ☐ routine ☐ urgent, needed by: | Sessions requested (AU: six if unspecified):

MHTP or PAMP prepared? ☐ yes, date: ☐ no ☐ n/a | Report back: ☐ after assessment ☐ end of course

Attachments: ☐ release / consent ☐ treatment plan ☐ score log ☐ other:

Signature (electronic accepted in AU and US): | Date signed:

Name / credentials:

Full guide, sample letter, and compliance notes:
bastiongpt.com/template/referral-letter