Psychiatric & Psychological Specialties
Comprehensive Mental Health Care.

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REFERRAL FORM

REFERRING PROVIDER INFORMATION

Provider Name: _____ Referral Date: _____

Phone Number: _____ Fax Number: _____

Contact Person: _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____ E-mail: _____

Contact Person: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

REFERRAL INFORMATION

Diagnosis: _____

Services Requesting: ☐ Individual Counseling ☐ Medication Management ☐ Psychological Assessment

Please send the following information with referral:

- Most recent visit note including reason for referral.
- List of current medications.
- Copy of insurance card(s).
- If available: Any previous psychological testing, psychiatric evaluations, psychiatric hospitalizations, etc.

Referral Notes: _____

_____

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THANK YOU FOR YOUR REFERRAL