# Outpatient Psychiatry PLLC

Patient Referral Form — Psychiatric Evaluation, Medication Management & Telepsychiatry

Fax: 1-866-497-1972
Phone: (972) 293-9795

Please complete this form and fax it to 1-866-497-1972. Our team will contact the patient directly to schedule.

*Ages 7 and up. In-person in Cedar Hill, TX; telehealth across TX, CA, NM, OR, WA, NY & MD.*

## Patient Information

PATIENT FULL NAME _____ DATE OF BIRTH _____ SEX _____

PATIENT / GUARDIAN PHONE _____ PATIENT ADDRESS (CITY, STATE, ZIP) _____

INSURANCE PLAN _____ MEMBER ID _____ GROUP # _____

## Reason for Referral

- ☐ ADHD
- ☐ Anxiety
- ☐ Depression
- ☐ PTSD
- ☐ Bipolar Disorder
- ☐ OCD
- ☐ Substance Use
- ☐ GeneSight Testing
- ☐ Medication Management
- ☐ Psychiatric Evaluation
- ☐ Other

BRIEF CLINICAL NOTES / CURRENT MEDICATIONS

_____

_____

Urgency: ☐ Routine ☐ Urgent ☐ Please call our office Records attached: ☐ Yes ☐ No

## Referring Provider

REFERRING PROVIDER NAME _____ PRACTICE NAME _____

PHONE _____ FAX _____ DATE _____

SIGNATURE _____



*Confidentiality notice: this form contains protected health information. If you received it in error, please notify the sender and destroy it.*