COMPLETE FAMILY PSYCHIATRY

PSYCHIATRY REFERRAL FORM

PERSONAL INFORMATION

Full Name :

Preferred Name :

Today's Date : _____ / _____ / _____ **Date of Birth** : _____ / _____ / _____

Address : _____

Phone Number : _____ **E-Mail :** _____

Ethnicity : _____ **Social Security Number** : _____

Gender Identity : ☐ Male ☐ Female ☐ Trans Male ☐ Trans Women ☐ Non-binary

Psychiatric Diagnosis : _____

_____

BILLING INFORMATION

☐ **Self-pay**

Insurance Provider: _____ **Member ID** : _____

Group ID : _____ **Phone Number** : _____

PRIMARY CARE PROVIDER

Your patient has opted to receive psychiatric-mental health care at Complete Family Psychiatry which may include the prescription of a controlled substances. This form certifies that the patient has been examined by you, a DEA-licensed medical provider, in person on the date below and you a referring this client to Complete Family Psychiatry for psychiatric-mental health care services.

Date of Last In-person Examination: _____ / _____ / _____

Provider Printed Name: _____

Provider Signature: _____

More Information :

99 6th Street SW, Suite 104
Winter Haven, FL 33880
407-268-6668
www.completefamilypsychiatry.com

FAX THIS FORM TO 407-214-8211