TELEPSYCHIATRY 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

Insurance Provider: ____________________ **Member ID** : ____________________

Group ID : ____________________ **Phone Number** : ____________________ ☐ **Self-pay**

PRIMARY CARE PROVIDER

Your patient has opted to receive psychiatric care via telemedicine at Complete Family Psychiatry which includes the prescription of 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 Examination: ______ / ______ / ______ **Provider Signature:** ____________________

OFFICE USE ONLY

Date : ____________________ **Membership Type** : ____________________

Membership Number : ____________________ **Payment Type** : ____________________

Staff Name : ____________________ **Staff Signature** : ____________________

More Information :

PO Box 1435 Winter Haven, FL 33882

1-877-417-APRN (2776)

www.completefamilypsychiatry.com

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Medical Provider Signature

FAX THIS FORM TO 863-884-1984