Piedmontpsychiatric.com

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NEW PATIENT REFERRAL FORM

DATE: ____/____/____ PHYSICIAN REQUESTED: ___________________________________

REFERRED BY:_________________________ OFFICE CONTACT: ___________________________________

REFERRAL EMAIL: ___________________________________ BACKLINE#: ___________________________

ADDRESS: _____________________________________ FAX#: _________________________________

PLEASE NOTE THAT WE DO NOT ACCEPT PATIENTS THAT ARE ELIGIBLE FOR MEDICAID OR HAVE THIS AS PRIMARY OR SECONDARY INSURANCE.

PATIENT INFORMATION (We will contact the patient to schedule appointment)

NAME ____ DOB ____/____/____ SSN _______________________

Parent Name (if minor) ___________________________________ Work Place ____________________________

HOME ADDRESS____

CITY ____ STATE ________________ ZIP ______________

HOME #(______) ______________________________ CELL #(______) ___________________________________

PRIMARY INS: ________________________________ **SECONDARY INS:** _______________________________

CHIEF COMPLAINT: ____

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PLEASE FAX COMPLETED FORM WITH MEDICAL RECORD AND INSURANCE CARDS TO 864-676-9432

ANY QUESTIONS, PLEASE CONTACT OUR REFERRAL COORDINATOR AT 864-676-9211 Ext. 143 or ssantay@piedmontpsych.com