



PIEDMONT PSYCHIATRIC SERVICES  
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: \_\_\_\_\_  
\_\_\_\_\_

**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](mailto:ssantay@piedmontpsych.com)**

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