PIEDMONT PSYCHIATRIC SERVICES

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NEW PATIENT REFERRAL FORM

DATE: ____/____/____ PHYSICIAN REQUESTED: ____

REFERRED BY ___________________________ REFERRAL OFFICE CONTACT_____________________

REFERRAL CONTACT EMAIL_________________________BACKLINE #___________FAX#____________

ADDRESS ____

*****WE DO NOT TAKE PATIENTS THAT ARE ELIGIBLE FOR MEDICAID OR HAVE THIS AS THEIR PRIMARY/SECONDARY INSURANCE*****

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

NAME _______________________________________ DOB ____/____/____ SSN ______________________

Parent Name (if minor) _________________________________ Work Place ___________________________

MAILING ADDRESS ____

CITY ____ STATE ______________ ZIP ____________

HOME#_____________________ WORK#_______________________ CELL#________________________

PRIMARY INS: ______________________________ **SECONDARY INS:** ______________________________

CHIEF COMPLAINT: ____

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*** PLEASE FAX COMPLETED REFERRAL FORM WITH A COPY OF MEDICAL RECORDS AND INSURANCE CARD(S) TO (864)676-9765 OR (864)676-9432**

*** ANY QUESTIONS, PLEASE CONTACT OUR REFERRAL COORDINATOR AT (864)676-9211 EXT. 137 or referrals@piedmontpsych.com**

*For Office Use Only: Appt. Date/Time ______________________________ Provider:_________________ Emailed/ Mailed Packet

Contacted referring doctor's office on______________________________