

REFERRAL FORM

- Shane Sherbondy, MD Tammy Gainey, NP
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225 Adley Way
Greenville, SC 29607
(864) 987-9747

FAX TO: (864) 987-9770

WE DO NOT ACCEPT MEDICAID

This cover letter plus _____ pages Date: _____

WARNING: This information contained in this facsimile message, and any documents attached to it, is confidential and may be legally privileged. It is intended solely for the use of the addressee. Access to this information by anyone else is unauthorized. If you are not the intended recipient, you are hereby notified that any disclosure, dissemination, duplication, or distribution of this information is strictly prohibited and may be unlawful.

IF YOU ARE NOT THE INTENDED RECIPIENT PLEASE NOTIFY OUR OFFICE IMMEDIATELY AT (864) 987-9747 AND DESTROY ALL COPIES OF THIS FAX.

Patient Information		HOW DID YOU HEAR ABOUT US?	
Name:		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	
Address:		City:	State: Zip:
Home Phone:	Cell Phone:	Please list: (Current Medications)	
Social Security #	Date of Birth:	Age:	
Emergency Contact Name:		Phone #	
Reason for Referral: (must be filled in)			
Diagnosis:			
Has patient ever seen a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes by whom? When?			
Primary Insurance Name:		Secondary Insurance Name:	
Policy ID #		Policy ID #	
Ins Ph #		Ins Ph #	
Policy Holder:		Policy Holder:	
Policy Holder DOB:		Policy Holder DOB:	
Policy Holders SSN:		Policy Holders SSN:	
Relationship to patient:		Relationship to patient:	
PLEASE FAX A COPY OF THE INSURANCE CARD WITH THE REFERRAL. Thank you!			

Referring Provider Information

Name of Facility:	Address:
Phone Number:	Fax Number:
Contact Person's Name:	
Referring Provider's Name:	
IMPORTANT: Patient must call their Insurance Company Prior to appointment with us to verify OUTPATIENT MENTAL HEALTH BENEFITS . And get PRIOR AUTHORIZATION if required. If this is not done patient will be required to pay in full at time of visit.	

PLEASE MAKE SURE YOU INCLUDE A SIGNED CONSENT AUTHORIZING RELEASE OF MEDICAL INFORMATION FROM PATIENT OR LEGAL GUARDIAN, DIAGNOSIS, CURRENT MEDICATIONS AND ALL PERTINENT MEDICAL RECORDS WITH THIS FAX REFERRAL FORM. WITHOUT THIS INFORMATION WE WILL NOT BE ABLE TO SCHEDULE AN APPOINTMENT FOR YOUR PATIENT.

Please Note: Once we have scheduled and/or attempted to schedule patient appointment you will receive this form as a fax back confirmation letting you know of appointment status.

Fax Back Confirmation

Fax back number:	Notes: _____ _____ _____ _____ _____
Fax back date:	
Appointment Date:	
Appointment Time:	
Appointment With:	

We would like to take this time to Thank you for referring patients to our practice.