Referring Provider -Referral Form
FAX TO: (864) 987-9770
This Cover plus _____pages
Date:_____

SHERBONDY'S
PSYCHIATRIC SOLUTIONS

225 Adley Way - Greenville, SC 29607
(864) 987-9747 x 21
Email:
sherbondysreferrals@sherbondyspsychiatric.com

WE DO NOT ACCEPT MEDICARE OR MEDICAID

WARNING: This information contained in this facsimile message, and any documents attached to it, is confidential and my 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 □ Female □**
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? □ Yes □ No	If yes by whom?	When?
Primary Insurance Name:		
Policy ID #		
Ins Ph #		
Policy Holder:		
Policy Holder DOB:		
Policy Holders SSN:		
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 RERCORDS 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.