

Self - REFERRAL FORM

Fax To: (864) 987-9770

Email To:

sherbondysreferrals@sherbondyspsychiatric.com

Date: _____



225 Adley Way
 Greenville, SC 29607
 PH(864) 987-9747 x 21
WE DO NOT ACCEPT
 Medicaid or Medicare

FORM MUST BE COMPLETELY FILLED OUT

Patient Information

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?	
Insurance Company Name:			
Policy ID #			
Ins Ph #			
Policy Holder:			
Policy Holder DOB:			
Policy Holders SSN:			
Relationship to patient:			
PLEASE Email, Fax and or Mail a copy of your Insurance Card front and back with this Referral. Thank you!			

Reason for Visit: Please write a brief description:

Thank you for your interest in our practice. We will be happy to assist you with an appointment once we have received your information back with this completed form. You can email, fax and or mail the information back to our office. Please make sure you include a copy of your insurance card front and back with this referral. **Sincerely, Sherbondy's Psychiatric Solutions**

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.