



PHYSICIAN REFERRAL FORM

Please note: Incomplete and/or illegible forms may be returned to the originating office, resulting in a delay in the patient's care.

****If a referral is urgent, phone notification is also recommended.**

**For non-urgent cases, the average wait time is approximately two weeks.

**Appointments for Psychological Assessment/Evaluations are triaged based on urgency.

Please indicate Release of Information (ROI):

Patient has signed release for PCP/Psychiatrist to coordinate care and does NOT require ROI from WellHome Psychology, PC.

PCP/Psychiatrist requires ROI from WellHome Psychology, PC to coordinate care.

REFERRAL DATE: _____

PATIENT NAME: _____

PARENT/GUARDIAN (if applicable): _____

DOB (MM/DD/YY): _____ PHONE: _____

INSURANCE: _____ MEMBER ID: _____

REFERRING PHYSICIAN: _____

OFFICE NUMBER: _____ FAX: _____

REASON FOR REFERRAL: _____

Physician Signature

Date

Total number of pages to be transmitted, including cover sheet: ____

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