A2Z MEDICINE PSYCHIATRIC REFERRAL FORM

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Sarasota Office: 8586 Potter Park Dr., Sarasota, FL 34238
Saint Petersburg Office: 600 1st Ave. N., Suite 307-B, Saint Petersburg, FL 33701

Date: ______________ **Type of visit:** ☐ Routine (within 30 day) ☐ Semi-Urgent (within 2 weels) ☐ Urgent (less than 48 hours)

Patient Information:

Patient Name: ______________________

DOB: ______________ Age: ______________

Gender: ______________________

Address: ______________________

City: ______________________

State: ______________ Zip Code: ______________

Telephone: ______________________

Email: ______________________

Primary Insurance: ______________________

Secondary Insurance: ______________________

POA/HCS Name: ______________________

Phone: ______________________

Referring Provider/Facility:

Provider Name: ______________________

NPI Number: ______________________

Specialty: ______________________

Phone: ______________________

Fax: ______________________

Facility Name: ______________________

Contact Name: ______________________

Phone: ______________ Fax: ______________

Address: ______________ City: ______________

State: ______________ Zip Code: ______________

Reason for Referral:

☐ New Consultation
☐ Transfer of Care
☐ Diagnose and Treatment
☐ Medication Management

Diagnosis Conditions:

☐ Anxiety
☐ Depression
☐ Sleep Disturbances/Insomnia
☐ PTSD (Post Traumatic Stress Disorder)
☐ Dementia/Cognitive Impairment
☐ Adjustment Disorders
☐ Mood Disorder/Bipolar Disorder
☐ Substance Abuse/Addiction
☐ ADHD (Attention Deficit Hyperactivity Disorder)
☐ Eating Disorders
☐ Schizophrenia
☐ Other: ______________________

Attached the Following:

☐ Demographics
☐ Health Insurance Card
☐ Medication List
☐ Exam Notes
☐ Lab
☐ Other

Thank you for entrusting us with your referral.