



WAKE PSYCHIATRY

REFERRAL FORM

Thank you for your referral. Our office staff will contact you to confirm that the referral has been received. Please discuss the intent of this referral with your patient. We will contact the patient to schedule an appointment.

Date of Referral _____	Referring Provider _____
Practice Name _____	
Phone _____	Fax _____
Office Contact _____	

Patient Name _____	DOB _____	Age _____
E-Mail _____	Phone _____	
Best time to contact patient	Morning	Mid-Day
		Afternoon

Reason for referral _____

Please fax or email completed referral with related documents
to **(919) 322-2416** or **New@WakePsychiatry.com**.
(Please include any documents related to their appointment & a copy of insurance card)

For Wake Psychiatry Use ONLY			
Date Received _____		1. _____	Sent _____
		2. _____	Uploaded _____
Office Staff _____	Pt Contact	3. _____	Appointment _____