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 ____

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Please fax or email completed referral with related documents

to (919) 322-2416 or info@wakepsychiatry.com

(Please include any documents related to their appointment & a copy of insurance card)

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