NEW PROVIDENCE HEALTHCARE

A Telepsychiatry Medical Practice

Patient Referral Form

PRIMARY CARE PROVIDER INFORMATION			
Primary Care Provider/ Agency:			**Date**
Contact Name	**Phone**		**Fax**
PCP Name (if different)			**PCP Phone**
PATIENT INFORMATION			
Name(Last)	**(First)**		**(M.I.)**
Address			
City	**State**	**ZIP**	**D.O.B**
Primary Phone Number		**Male / Female**	**AGE**
E-mail			
Parent/ Guardian (if applicable)			**D.O.B**
Name		**Male / Female**	**AGE**
Full Address			
Primary Phone Number			
E-mail			
INSURANCE INFORMATION			
Primary Insurance			***(Photocopy of Insurance Card(s) and ID Required)***
Cardholder Name	**Relation to Patient**		**Cardholder D.O.B.**
Cardholder Employer	**Contact ID**		**Group No.**
Secondary Insurance			
Cardholder Name	**Relation to Patient**		**Cardholder D.O.B.**
Cardholder Employer	**Contact ID**		**Group No.**
CLINICAL INFORMATION			

5627 Allentown Road, Suite 100 Camp Springs, MD 20746
(Office) 301.899.8910 (Fax) 301.899.8915

Symptoms (check all that apply and/or describe below):	List Current Medication
☐ Abuse / Neglect ☐ Aggression / Violence ☐ Delusions ☐ Dementia ☐ Depression ☐ Disoriented / Confused ☐ Eating Disorder ☐ Family Relationship Problems ☐ Gambling Addiction ☐ Homicidal Thoughts ☐ Hyperactivity ☐ Anxiety, Fear, Panic ☐ Paranoia ☐ Hallucinations ☐ Obsession / Compulsion ☐ Self-Injury ☐ Substance Abuse ☐ Suicidal Thoughts ☐ Other	

Diagnosis

Additional Comments/ Concerns

Has the patient previously participated in therapy?	No	Yes / When?

Submit Form to admin@newprovidencehealth.org or by Fax 301-899-8915

5627 Allentown Road, Suite 100 Camp Springs, MD 20746
(Office) 301.899.8910 (Fax) 301.899.8915