



## 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 are triaged based on urgency.

**Please indicate Release of Information:**

Patient has signed release for Primary Care Provider to coordinate care and does NOT require ROI from WellHome Psychology, PC.

Primary Care Provider 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

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

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