*****ALL REQUESTED INFO ON THIS REFERRAL FORM IS REQUIRED IN ORDER FOR PATIENT TO BE SCHEDULED. *****
PLEASE ATTACH THE PATIENT'S DEMOGRAPHICS/FACESHEET AND MOST RECENT OFFICE NOTE.

Lighthouse Psychiatry & Behavioral Health Clinic

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www.lighthousepsychal.com

Angela Waldrop, PMHNP-BC | **Katy Cousart, PMHNP-BC**

Doris Bell, LICSW | **Gretchen Shay, LICSW**

Patient Referral Form

Please circle which provider you would like to refer to and Fax form to 866-896-3657

*****You will receive a fax confirmation for the appointment within 7 working days*****

Patient Name: _____ **Social Security#:** _____-____-_____ DOB: _____

Phone #: _____ *Email: _____

Referring Office Information:

Provider Name: _____ Phone #: _____

Staff Contact Name: _____ Fax #: _____

Please attach pertinent info: X Demographics X Last Office Visit ____Recent Labs

Patient Insurance Information:

Primary Insurance: _____ Policy #: _____

Policy Holder: _____ Policy Holder DOB: _____

Relationship to Policy Holder: _____

Secondary Insurance: _____ Policy #: _____

Policy Holder: _____ Policy Holder DOB: _____

Relationship to Policy Holder: _____

Reason for Referral: Medication Management or Individual Therapy (include diagnosis/symptoms)

_____

_____

_____

********OFFICIAL USE ONLY********

☐ **Scheduled** **Appt Date/Time:** _____ **Provider:** _____

☐ **NOT Scheduled** **CALLED PATIENT ON** ____/_____/____ **and LVM to return our call to schedule.**

☐ **OTHER:** _____.

We are currently unable to accept new or transfer patients requesting treatment with a controlled substance of any kind including any stimulants that treat ADD and ADHD. We will only prescribe non-stimulant medications. If the non-stimulant medications are not effective, we are able to provide a list of providers we recommend for you to contact