REFERRAL FORM

The Haymount Institute

for Psychological Services

Today's Date:_____

Referring Company Name: _____ **NPI:** _____

Referring Physician Name: _____ **NPI:** _____

Phone No: _____ **Fax No:** _____ **Contact Person:** _____

Type of Service requested: **( ) Psychiatric Consultation/ Medication Management**

( ) Psychological/ Neuro Evaluation **( ) Forensic Evaluation** **( ) Medical/ Pre-Surgical Evaluation**

( ) Biofeedback **( ) Individual Therapy** **( ) Family/ Marital Therapy** **( ) Autism Clinic**

Diagnostic Impression: _____

Is the patient aware of this referral? **( ) Yes ( ) No** **Male or Female**

Can a confidential message be left on the patient's voicemail? **( ) Yes ( ) No**

Patient Information:

Last: _____ **First:** _____ **MI:** _____ **DOB:** _____

Parent/ Guardian Name: _____

Patient SSN: _____ **Address:** _____

Phone No: Home _____ **Cell:** _____ **Work:** _____

Please fill out completely and send a legible copy of insurance card:

Primary Insurance: _____ **Phone No:** _____

Subscriber's Name: _____ **DOB:** _____

Subscriber's ID: _____ **SSN:** _____ **Group No:** _____

Secondary Insurance: _____ **Phone No:** _____

Subscriber's Name: _____ **DOB:** _____

Please fax this form to:

Fayetteville Location (910)-221-9006 Hope Mills 910-339-0904

Raeford Location 910-848-0222

Office Use only:

Appt Scheduled for: _____ **with** _____

NOT Scheduled for the following reasons: **( ) Unable to Contact** **( ) Pt. Declined Services**