Psychiatry Evaluation and Medication Management Referral Form

Sherman Counseling

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www.shermanconsulting.net
Phone: 920.733.2065, option #3 for psychiatry
Fax: 844.364.6240

To be completed by: Therapist, Primary Care or OB/GYN Clinician

Referring Clinician or Therapist: _____

Referrer's contact number: _____

Patient Name _____

Patient phone number(s): _____

Patient DOB: _____

Health Insurance: _____

Patient's Primary Care Provider:_____

Patient's most recent prescriber of psychiatric medications:_____

Current psychiatric medications, if any: _____

_____

Reason for Referral: _____

_____

_____

Requested Provider: ___Tasha Farrar MD ___ Joelle Fellinger, APNP ___ Either

Please fax the following to (844) 364-6240:

1. This form
2. A signed Release of Information (ROI) for you, the referrer
3. An ROI for the patient's primary care provider (PCP) and/or most recent psychiatric prescriber
4. Relevant medical records if available. A medication list and medical problem list are appreciated

This referral will be reviewed by one of our providers. Please be aware that should the patient's needs be better met by services elsewhere, you will be notified. Our exclusion criteria is available on the Sherman website.

Please feel free to contact us with any questions. Thank you for your referral.