OUTPATIENT CLINIC REFERRAL FORM

Fax to 318-333-3075

Please complete all sections of this form, preferably by typing. Your patient will receive a phone call with the details of their scheduled appointment. For all inquiries please telephone 318-303-3077. Please call Epiphany Health with an urgent referral.

Patient details

Last Name:________________________ First names:______________________________

Date of birth:______________________ Sex: Male ☐ Female ☐

If under 18, provide Guardian's Name: ____

Address:____

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Preferred contact number: Mobile*____________________(2) Other _______________________

Insurance Name: _____________________________ Member number #:____________________

*** Mobile number used to send SMS reminder before appointment.**

Clinical details

Clinic required:

☐ **Psychiatric Med Mgmt** ☐ **Suboxone Therapy** ☐ **Medical Marijuana Recommendations**

Reason for referral / diagnosis:____

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Relevant past history:____

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Please include a list of current medications, any relevant pathology and imaging results with this referral. This information will assist us to appropriately triage your patient.

Referral duration: ☐ 3 months ☐ 12 months ☐ Indefinite ☐ Other_____________

Referring doctor details

Name:____________________________

Address:_________________________________ Email: ____

____

Telephone number:________________________

Fax number:______________________________

Doctor's signature:_______________________

Date:____________________________________

Preferred contact: ☐ Telephone ☐ Fax ☐ Email:______________________________________

Office use only

Date received_______________ Clinic______________________Triage_________________________

2007-08