Rhonda Therese Rushing, LLC
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Office: 318-303-3077
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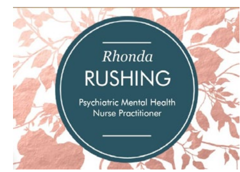

PSYCHIATRIC MEDICATION MANAGEMENT REFERRAL FORM

Fax to 318-333-3075

Use this form ONLY for Rhonda Therese Rushing, LLC patients who require psychiatric medication management.
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 with an urgent referral.

Patient details

Last Name:________________________ First names:______________________________

Date of birth:________________________ Sex: Male ☐ Female ☐

If under 18, provide Guardian's Name: ____

Address:____

____

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

Insurance Name: _____________________________ Member number #:____________________

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

Clinical details

Clinic required:

☐ **Psychiatric Medication Management**

Reason for referral / diagnosis:____

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Relevant 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________________________