Patient Referral Form

Cornerstone Psychiatric Services, Inc.

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Medical Records and Referral Fax: (941) 375-0119

REFERRAL SOURCE

Date of Referral: ___________________________________
Referral is from: ___________________________________ ☐ MD/D.O. ☐ PA/APRN/ARNP ☐ PhD/PsyD ☐ LCSW/LMHC ☐ Other

Contact Phone: (_____)_____-_________ **Fax#:** (_____)_____-_________

To assist in the assessment & referral process, please forward (fax or mail) a copy of the patient's face sheet, the most recent progress note detailing the reason for this referral, recent lab results and the most recent printed medication list with dosages. If available, a copy of the most recent psychiatric evaluation and/or history & physical examination will be helpful, although, they are not required for the assessment to be done.

Name of Person Completing Referral Form: ____

PATIENT INFORMATION

Last Name:_________________________ **First Name:**_______________________ **Middle Name:**_______________

Suffix: __JR __SR __III __IV or ______ **Preferred Name:**_____________________**Date of Birth:**____/____/____

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed

SSN:______-_____-______ **Spouse Name:**______________________**Contact#:**(______)______-_______

Street Address:____________________________ **City:**_________________________ **State:**___________ **Zip:**_____________

Email*:___________________________________ **Home#:** (_____)______-________ **Mobile#:**(_____)_____-_________

*Your email will be used to invite you to Patient Portal access.

Work#:(_____)_____-_________ **Other#:**(_____)______-_________

Race: ☐ White – Non Hispanic ☐ Black – Non Hispanic☐ American Indian/Alaskan Native ☐ Pacific Islander ☐ Asian ☐Other:_______

Ethnicity: ☐Hispanic ☐ Non-Hispanic ☐ Unknown **Language:** ☐ English ☐ Other:_______________

Primary Payer/Insurance: ☐ Self pay ☐ Aetna ☐ BCBS/FL BLUE ☐ Cigna ☐ Golden Rule ☐ Magellan ☐ Medicare (traditional)
☐ Medicare Advantage:________________________ ☐ Tricare ☐ United Healthcare/UBH ☐ Other:______________________

Insurance ID#:___________________________________ **Group#**________________ **COPAY for MH (if known):**___________

Secondary Payer (if any):____________________________________ **ID#:**_______________________**Group#:**_______________

CLINICAL INFORMATION

Included Documentation: ☐ Progress Note(s) ☐ Psychiatric Evaluation ☐ Medication Record ☐ Lab Results
☐ Verbal Report From:____

Reason for Referral / Concerns:

Clinical Summary:

Fax Completed form to (941) 375-0119. Someone from the office will contact the patient or patient's guardian to schedule an appointment as soon as possible. If you have any immediate concerns please contact the office at (941) 488-8884.
Please remember we are not set up for emergency type appointments. Thank you for your referral.

Assigned CPS Patient Account#:_____________ **CPS Appointment Date/Time:**____________________________________