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## PSYCHIATRIC REFERRAL FORM

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Needs by Date: \_\_\_\_\_

Language: \_\_\_\_\_  Nursing Instruction Required

Ship to:  Patient  MD Office

Prescriber's Name: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

### PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  F  M

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_ Email: \_\_\_\_\_

### PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

#### CLINICAL INFORMATION

Clinical Evaluation	
Primary Diagnosis: _____	ICD-10 Code: _____
Secondary Diagnosis: _____	ICD-10 Code: _____
Other Diagnosis: _____	ICD-10 Code: _____
Other Diagnosis: _____	ICD-10 Code: _____

#### PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	MAX. DAILY DOSAGE	SIG	QTY.	REFILLS
<input type="checkbox"/> Abilify Maintena Injection	<input type="checkbox"/> 300mg <input type="checkbox"/> 400mg		<input type="checkbox"/> One injection every 4 weeks		
<input type="checkbox"/> Invega Sustenna Injection	<input type="checkbox"/> 39mg <input type="checkbox"/> 117mg <input type="checkbox"/> 234 <input type="checkbox"/> 78mg <input type="checkbox"/> 156mg		<input type="checkbox"/> One injection every 4 weeks <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Invega Trinza ER injection	<input type="checkbox"/> 27mg <input type="checkbox"/> 410mg <input type="checkbox"/> 546mg <input type="checkbox"/> 819mg		<input type="checkbox"/> One injection every 3 weeks		
<input type="checkbox"/> Risperdal Consta Injection	<input type="checkbox"/> 12.5mg <input type="checkbox"/> 25mg <input type="checkbox"/> 37.5mg <input type="checkbox"/> 50mg		<input type="checkbox"/> One injection every 2 weeks		
<input type="checkbox"/> Latuda Tab	<input type="checkbox"/> 20mg <input type="checkbox"/> 40mg <input type="checkbox"/> 120mg <input type="checkbox"/> 60mg <input type="checkbox"/> 80mg				
<input type="checkbox"/> Rexulti Cap	<input type="checkbox"/> 0.25mg <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 2mg <input type="checkbox"/> 3mg <input type="checkbox"/> 4mg				
<input type="checkbox"/> Vraylar	<input type="checkbox"/> 1.5mg <input type="checkbox"/> 3mg <input type="checkbox"/> 4.5mg <input type="checkbox"/> 6mg				

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT NOTICE:** This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

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