JAUREGUI PSYCHIATRY

PROVIDER REFERRAL FORM

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Optional form; your existing referral packet is also welcome.

* Essential information. Use Unknown when appropriate.

FAX REFERRALS TO

(737) 200-8347

1 PATIENT INFORMATION

Full legal name*

Date of birth*

State for visits*

Patient / guardian phone*

Patient email (preferred)

Preferred language*

For adolescents: guardian name, relationship, and contact*

Aware of referral? Yes / No / Unknown*; safe contact method, voicemail permission, best time

2 REFERRING PROVIDER

Provider name and credentials*

Practice / organization*

Office callback number*

Return fax or Direct address*

Referral date*

3 REFERRAL DETAILS

Reason / requested service* (evaluation, medication management, diagnostic clarification, other)

Urgency and known safety concerns* (include Unknown / Not assessed if applicable)

Preferred: symptoms, diagnoses, medications / allergies, prior treatment, recent hospitalizations

Preferred: insurance plan / private pay / unknown; relevant records attached (list)

Attach relevant clinical notes, medication list, or referral letter if available.

Referral submission does not confirm acceptance or an appointment. Our office will review and contact the patient.

Not an emergency service. Do not use this form for an immediate safety concern; call 911 for an emergency.

Contains confidential patient information when completed. Verify the destination fax before sending.