8687 E. Via de Ventura, Suite 310
Scottsdale, AZ 85258
Phone: (877)216-9880 / Fax: (800)507-4593
PsychConnect.com

PROVIDER REFERRAL FORM

Referring Provider Information

Name of Referring Provider:			Date of Referral:
Referring Practice/Group/Organization:			Phone:
Street Address:			Fax:
City:	State:	Zip:	Email:

Facility Type:

Inpatient Hospital
Primary Care Clinic
Emergency Dept/Urgent Care
Pharmacy
Other_________________________________

Patient Information and Insurance

First Name/Last Name:			Date of Birth:
Email:			Phone:
Street Address:			
City:	State:	Zip:	Gender Identity (M/F/Gender Diverse):
Primary Care Provider Name:	Primary Care Provider Practice:		Phone:
Primary Care Provider Address & City:	State:	Zip:	Email:

Services Requested (check all that may apply):

Evaluation Only
Medication Management Only
Evaluation & Medication Management
Counseling
Other_____________________________

Explanation of Patient's Mental Health Diagnosis/Symptoms:

Patient Insurance

Insurance Provider:	Policy Holder Name:
Group Number:	Policy Number:

I hereby confirm that I have obtained patient consent to release patient information to PsychConnect.

Please complete the entire referral and submit to PsychConnect via email hello@psychconnect.com or FAX to (800) 507-4593.

rev 01.11.2022