PSYCHCONNECT
A FasPsych Service

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psychconnect.com

PROVIDER REFERRAL FORM

Provider Information

Name:			Email:
Referring Practice/Group/Organization:			Phone:
Address:			
City:	State:	Zip:	Fax:

Facility Type

☐ Inpatient Hospital ☐ Primary Care Clinic

☐ Emergency Dept. / Urgent Care ☐ Pharmacy ☐Other _____

Patient Information

First Name/Last Name:			Date of Birth:
Email:			Phone:
Address:			
City:	State:	Zip:	Gender Identity (M/F/Gender Diverse)

Services Requested (check all that 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 online referral and submit to PsychConnect via email, hello@psychconnect.com or fax (480) 970-5318