223 East Second Street, Suite B – Post Office Box 1613 – Tifton, Georgia 31793
Phone: (229) 339-3721 - Fax: (229) 472-9151 – www.TiftareaPACS.com – info@TiftareaPACS.com

Provider Referral Form

PATIENT INFORMATION:

Client (Patient) Name: ______________________________ Date of Birth: ______________ Client Age: ____________

Client Telephone: (Home)______________________(Cell)_______________________(Other) _____________________

Client Address: ____

INSURANCE INFORMATION:

- A copy of insurance card front and back may be included in lieu of completing this section -

Primary Insurance Provider: ________________________________ Policy Number: _____________________________

Insurance Provider Phone: _________________ Policy Holder: ___________________ Relationship: ________________

Secondary Insurance Provider: ________________________________ Policy Number: ___________________________

Insurance Provider Phone: _________________ Policy Holder: ___________________ Relationship: ________________

REFERRAL INFORMATION:

Referring Provider:____________________________________ Referral Source Telephone: _______________________

Reason for Referral:

[ ] Depression	[ ] Anxiety	[ ] Career Counseling	[ ] Family of Origin Issues
[ ] Coping Skills	[ ] Grief	[ ] Life Stressors	[ ] Behavior Problems
[ ] Psychosis	[ ] Trauma	[ ] Substance Abuse	[ ] Anger Management
[ ] Bipolar Disorder	[ ] Other: ______________________________		

Comments: ____

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Current Medications: ____

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Are records included? YES / NO

Is Release of Information being sent with referral? YES / NO

Please fax referrals to: (229) 472-9151