EVANSVILLE PSYCHIATRIC ASSOCIATES

We need the following to schedule your patient:
❍ Demographics ❍ Recent progress notes
❍Insurance card(s), front and back

FAX # 1-812-671-0627
Phone # 1-812-422-7974

REFERRING PROVIDERS: Please fax us this form and include the information below.
*You may also encourage your patient to register directly with us on-line at **evansvillepsychiatric.com** and fax us the supporting information .*
Thank you for the opportunity to assist in your patient's care.

Referring Provider: _____ Date: _____

Contact Name for further information: _____

Contact Phone number: _____ Contact Fax number: _____

_____

Patient Name: _____ DOB: _____

Address: _____City/State: _____Zip:_____

Cell#_____ Home#_____Work#/ext_____

Patient E-mail: _____ SSN:_____

❍ Insurance Information / Copies of Cards
- Include Subscriber Demographics

❍ Last 1-3 pertinent progress notes
❍ Working diagnosis/brief summary:
_____
❍ Medication(s) patient taking?
_____

Failed Medication(s)? _____

Is this patient seeking disability? _____

Any previous psychiatric admissions/information? _____

History of drug/alcohol abuse: _____

We will contact your patient to schedule with the most appropriate clinician.

Do you wish to refer to a specific clinician?_____

Thank you for your referral!