MD Psychiatry & Emotional Health, PLLC

Help. Heal. Hope.

Date: _____

Location: ☐ Cary ☐ Durham

New Patient Referral Request

Please fax requests to: (984) 333-9160

Or Email us at: request@mdp-ehd.com

Referred by: _____

Practice Name: _____

Phone Number: _____ **Fax Number:** _____

Patient Name: _____ **Date of Birth:** _____

Address:_____

_____

Phone Number: _____ **Email Address:** _____

Preferred Pharmacy: _____

Parent or Guardian (if applicable): _____

Relationship to Patient: _____

Primary Insurance:

Subscriber/Member ID/Policy #: _____ **Group #:** _____

Name and Relationship to Policy Holder: _____

Secondary Insurance:

Subscriber/Member ID/Policy #: _____ **Group #:** _____

Name and Relationship to Policy Holder: _____

Reason for Referral: _____

_____

Recent Psychiatric Hospitalization: ☐ Yes ☐ No

Current Medication List: _____

_____

Preferred Pharmacy:

_____