Stephens Psychiatry

Jeff Stephens, MD | Cara Reeves, PhD

Provider Referral Form

Referring Provider/Practice: **Date:**

Preferred Fax or Email for Referral Follow Up:

Patient Name: **Date of Birth:**

Phone: **Email:**

Parent/Guardian Info if under 18 years of age:

Parent Name: **Phone:** **Email:**

Is the patient currently seeing or has the patient seen a psychiatrist in the past?

I am referring this patient to: ☐ **Jeff Stephens, MD** ☐ **Cara Reeves, PhD**

Is the patient or responsible party aware that our office is self pay?

For more on this please refer to the cost of our services listed on our website: www.jeffstephenspsychiatry.com

Reason for Referral/Clinical Information: (Please provide any relevant clinical information here, diagnosis, previously failed medications, office notes, etc.) We accept new patients on a case by case basis. We will notify you if we are unable to accommodate this referral. We will make three attempts to schedule if accepted.

Please return this form completed to stephenspsychiatry@gmail.com or by fax 864-520-1124.

☐ **We are unable to accommodate this patient. Please refer elsewhere.**

☐ **This patient has been scheduled, appointment date/time:**

☐ **We have unsuccessfully made 3 or more attempts to contact this patient to schedule.**