

**TELEMEDICINE REFERRAL**

**Date of Referral:** Click or tap to enter a date.

**Referring Practice:** Choose an item. **Phone No.** Click or tap here to enter text.

**Referring Provider:** Choose an item. **Fax No.** Click or tap here to enter text.

**Have you previously consulted with PATHS regarding this patient?  Yes  No**

**Patient Name**: Click or tap here to enter text. **Gender**:  Male  Female **DOB**: Click or tap to enter a date.

**Address:** Click or tap here to enter text. **City:** Click or tap here to enter text.**Zip Code:** Click or tap here to enter text.

**Best Phone Number**: Click or tap here to enter text. **Person to Call:** Click or tap here to enter text.

**Please check appropriate box to indicate patient’s insurance**:  Medicaid  BCBSAL  ALL Kids  Other Click or tap here to enter text.

**Member Policy #:** Click or tap here to enter text.

**Name of Insured**: Click or tap here to enter text. **Insured’s DOB**: Click or tap to enter a date.

**Relationship to Patient**: Click or tap here to enter text.

**Is parent/patient aware of referral?** Choose an item.

**Reason for Referral:** Medication ManagementPsychotherapy ReferralDiagnostic Assessment

Care CoordinationOther Please specify: Click or tap here to enter text.

**Current Medications (please list all):** Click or tap here to enter text.

**Primary Presenting Problems:** Click or tap here to enter text.

