



NEW PATH PSYCHIATRY

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Referral for New Path Psychiatry Services

Full Name of Referring Provider: _____

Practice or Clinic Name: _____

Provider Contact Number: _____ Email Address: _____

Patient Details:

Patient's Full Name : _____ Date of Birth : _____

Preferred Name : _____ Pronouns: _____

Phone Number: _____ Email Address: _____

Reason for Referral:

Primary Diagnosis/ Concern: _____

Brief Overview of Current Symptoms/Issues: _____

Insurance Information:

Insurance Provider: _____

Policy Holder Name & Number: _____

Patient's Preferred Date and Time of Service: _____

Emergency Contact (if applicabe)

Contact Name: _____

Relationship to Patient: _____ Phone Number: _____

Other relevant information/goal: _____

Consent for Referral (verbal or written): _____ Date: _____

I, the undersigned, hereby consent to the referral of the above-named patient to your outpatient behavioral health services. I understand that this information is being shared for the purpose of facilitating the patient's mental health care and the patient has been informed about the referral.

Referring Provider's Signature: _____

Date: _____

Please send the completed form to our secure fax **720-802-7462** or via encrypted email to **support@newpathpsychiatryco.com**. Thank you for partnering with us to support the mental health of our community.