

Saucier Psychiatry

PATIENT REFERRAL FORM

Fax: (984) 220-9351 Phone: (910) 273-7572

4820 Six Forks Rd, Suite 100, Raleigh, NC 27609

Office hours: Monday–Friday, 9:00 am – 6:00 pm

We aim to call your patient within one business day of receiving this referral.

This form is not for emergencies. For a patient in crisis, call 988 or 911, or go to the nearest emergency department.

Date of referral

Please print clearly or fill in on screen. All fields help us reach your patient faster.

1. REFERRING PROVIDER

Provider name

Credentials (MD, DO, NP, PA...)

NPI

Practice / organization

Phone

Fax

Best callback / contact person

Email (for scheduling coordination only, no patient health information)

Practice address

2. PATIENT INFORMATION

Patient full name

Date of birth (MM/DD/YYYY)

Phone

Preferred contact

☐ Phone call ☐ Text message ☐ OK to leave voicemail

Preferred language

☐ English ☐ Spanish / Español ☐ Other:

Parent / legal guardian name (if patient is a minor)

Relationship

Guardian phone

3. INSURANCE

Insurance plan name

Member ID

Group # (if known)

4. REASON FOR REFERRAL (CHECK ALL THAT APPLY)

☐ Psychiatric evaluation ☐ Medication management ☐ Therapy ☐ ADHD assessment

☐ GeneSight testing ☐ Spravato evaluation ☐ Other:

Presenting concerns / clinical question (symptoms, duration, what has been tried, what you would like from us)

5. CLINICAL INFORMATION

Current medications (name, dose, frequency)

Diagnoses / ICD-10 codes (if known)

Allergies

☐ No known drug allergies

6. URGENCY AND ATTACHMENTS

Urgency

☐ Routine ☐ Soon (please prioritize)

Attached (please include if available)

☐ Recent notes ☐ Medication list ☐ Labs ☐ Other:

Urgent safety concerns: do not fax and wait. Call 988 or 911, or send the patient to the nearest emergency department.

7. PATIENT CONSENT AND PROVIDER SIGNATURE

☐ The patient is aware of and agrees to this referral to Saucier Psychiatry.

Referring provider signature

Printed name

Date

HOW TO SEND Fax this form and any attachments to (984) 220-9351. Questions? Call (910) 273-7572, Monday–Friday, 9 am–6 pm.

Please send patient information by fax or another secure channel only, never by regular email.

We aim to call your patient within one business day of receiving the referral and keep you updated on next steps.

For office use: Date received _____ Patient contacted _____ Initials _____

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