Kiran Shashi Devaraj, MD
Hillard Brown, APRN-FNP
Nicole Lim, APRN- FNP
Michele Long, APRN- FNP
Cheri Call, APRN- FNP

Cathy Rasnake, LPC, AADC, MAC
Nikki Erwin, MA, LPC
Monica McMillian, M.A., Licensed Psychologist
Trinity Nicholas, MSW, LICSW

Medical Providers
100 Peyton Way, Suite 200
South Charleston, WV 25309
Phone: (304) 513-3513
Fax: (304) 513-3519

Therapy Providers
1520 Kanawha Boulevard, East
Charleston, WV 25311
Phone: (681) 265-9047
Fax: (681) 265-9208

NEW PATIENT REFERRAL FORM

Date of Referral: _____ Employee Initials: _____

Referring Doctor/Source:_____

Referral Source Phone:_____ Fax:_____

Referral Source Email:_____

PATIENT INFORMATION

Patient Name: _____ □Male □Female

Patient's Legal Guardian (*if minor*): _____

Patient's Address:_____

City:_____ State:_____ Zip:_____

Patient's Social Security: _____ DOB: _____ Age: _____

Home phone: _____ Cell phone:_____

PATIENT IS REFERRED FOR:

□ Medication Management
(medication prescribed by medical provider)

□ Psychotherapy
(individual therapy without medication)

Has the patient previously received mental health services from a psychiatrist, therapist or psychologist? If so, please list the provider(s) and dates of services received:

_____

_____

What are the patient's current symptoms/how long have they been an issue? _____

_____

Current medications:_____

_____

PLEASE NOTE: Our office will make <u>two</u> attempts to contact the patient to schedule an appointment. After two attempts have been made it is the patient's responsibility to contact the office to schedule an appointment.

INSURANCE INFORMATION

Please complete entirely

Primary Insurance: _____

Identification number: _____

Name of policyholder: _____

Relationship to patient: _____ DOB of policyholder: _____

SS# of policyholder: _____ Employer: _____

Secondary Insurance: _____

Identification number: _____

Name of policyholder: _____

Relationship to patient: _____ DOB of policyholder: _____

SS# of policyholder: _____ Employer:_____

a copy of the front and back of the insurance card is required

PLEASE FAX THIS FORM TO 304-513-3519

THANK YOU FOR THIS REFERRAL!