

Psychiatry & Therapy Referral Request

California | Texas | Florida

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OUTPATIENT REFERRALS ONLY. Do not use this form for emergencies. For immediate danger or a medical emergency, call 911 or go to the nearest emergency department.

Complete both pages; repeat patient name and DOB on page 2. Fax to intake. Call intake for receipt or referral status. Do not send completed forms or patient records to the general support email.

1 REFERRING PROVIDER & REFERRAL PRIORITY

Referral date (MM/DD/YYYY)

Priority (select one)

☐ Routine ☐ Priority outpatient

For time-sensitive referrals, also call intake.

Referring practice / organization

Referring clinician name & credentials

Direct phone / backline

Return fax for referral updates

NPI (if available)

Completed by / contact person & role

Reason for priority, if selected

2 PATIENT INFORMATION & SAFE CONTACT

Patient full name

Date of birth (MM/DD/YYYY)

Residence state / ZIP

Safe phone number

Safe email address (if available)

Preferred contact method (select one)

☐ Phone ☐ Email ☐ Discuss with patient

May leave scheduling voicemail?

☐ Yes ☐ No ☐ Unknown

Patient informed of referral? (select one)

☐ Yes ☐ No ☐ Unknown

Expected state during telehealth (select one)

☐ CA ☐ TX ☐ FL ☐ Unknown ☐ Other*

*Tell intake. Location is reconfirmed at each visit.

Other contact restrictions / access needs

Preferred language / interpreter needs

Parent / guardian / representative, if applicable: name, relationship & safe phone

Intake must verify representative authority and applicable consent rules.

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Repeat patient full name

Repeat date of birth

3 CLINICAL REASON & REQUESTED SERVICE

Service requested (check all that apply)

☐ Psychiatric evaluation / medication management☐ Psychotherapy / counseling

Symptoms / referral reason, duration & known or suspected diagnosis (if available)

Known current safety concerns & action already taken, if applicable

Current medications: name, dose, frequency & prescriber (or attach list)

Allergies / reactions (none known / unknown / list)

Recent psychiatric discharge: date / facility, if any

4 INSURANCE / PAYMENT INFORMATION

Coverage (select one)

☐ Insurance☐ Self-pay / uninsured☐ Unknown

Primary insurance carrier / plan

Member ID / group number

Subscriber name / DOB / relationship, if different

Secondary insurance / member ID, if any

5 ATTACHMENTS & DISCLOSURE SAFEGUARDS

Attachments included (check all that apply)

☐ Demographics / face sheet☐ Insurance card(s)☐ Relevant clinical summary☐ Medication / allergy list☐ Required authorization☐ Discharge summary

Before sending, the referring practice must verify a lawful disclosure basis under applicable federal and state law. Attach a valid authorization when required. This referral request, patient-awareness response and contact preferences are not consent to treatment or a release authorization.

Do not attach separately maintained psychotherapy notes. For records protected by 42 CFR Part 2 or stricter state confidentiality rules, confirm applicable consent and disclosure requirements before sending.

CONFIDENTIALITY: Intended for Savant Care Intake. Use or disclose only as authorized or permitted by applicable federal and state law. If received in error, notify the sender promptly, do not use or further disclose the information, and securely destroy the unintended copy.