Physician Referral Form

C. David Blair, Ph.D. • Center For Health Psychology, Inc.
179 Summers Street, Suite 710 • Charleston, WV 25301

Date: _____

From: Provider Name: _____

Provider's Address: _____

_____

Telephone Number: (_____) _____-_____ Fax: (_____) _____-_____

Patient Name: _____
First Middle Last

Address: _____
Street or PO Box City State ZIP

Date of Birth: _____ Gender: M F SSN: _____ _____

Phone: _____ _____
Home / Cell Message OK? Y N Work / Cell Message OK? Y N

Spouse (*if married*): _____ _____
Name Phone

Parent/Guardian (*if minor*): _____ _____
Name Relationship

Insurance: _____ _____
PRIMARY SECONDARY

Reason For Referral / History: (Please include psychiatric history, psychiatric treatment, psychiatric medications, and hospitalizations. Please attach a copy of all pertinent records.)

_____
_____
_____
_____

Medications: (Attach a separate sheet, if necessary)

_____
_____

Signature of Requesting Provider: _____

Please fax this form to (304) **342-8311**, with a copy of the pertinent **MEDICAL RECORDS** and an **ENLARGED** copy of the patient's **INSURANCE CARD(s)** (front and back, please).

Please advise your patient that you are making this referral – it makes the initial contact much easier. We will contact the patient with an appointment time as soon as possible.

If you have questions, please call (304) **342-8300**.
(Please Note: We do not accept Carelink, Magellan, or Medicaid at this time.)