The Psychiatry Group
Psychiatric Referral Form

Note: Please return the filled referral form at info@psychiatrygroup.com or Fax to:

1. Patient Information:

First Name:

Last Name:

Date of Birth : **Gender:**

Address 1:

State:

City: **ZIP Code:**

E-mail:

Phone:

Mobile:

Best time to Contact:

2. Referral Provider/Source:

Referring provider:

Contact Person:

Phone:

Email:

Fax:

Source of Referral:

☐ **Google** ☐ **Word of mouth** ☐ **E-mail received** ☐ **Health system**

Other: _____

3. **Reason for Referral (check all that apply)**

☐ TMS (Transcranial Magnetic Stimulation) (Spokane only)
☐ Esketamine / Ketamine Therapy (FDA-approved) (Spokane only)
☐ Medication Management / Psychopharmacology (WA, OR, ID, CA)
Psychotherapy / Counseling (WA, ID)
☐ Labor & Industries / Work-injury psychiatric evaluation
Second Opinion / Reassessment
☐ Independent Medical Evaluation/ Impairment rating

☐ Other (please specify): _____

_____

4. **Clinical/Diagnostic information:**

Primary Diagnosis (if known):

_____

_____

_____

Secondary/Comorbid Diagnoses:

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5. Additional Documents / Attachment:

Please attach or fax any of the following, if available:

- Recent psychiatric / therapy notes
- Neuropsychological or neurologic reports
- Imaging / brain injury reports
- L&I or Workers' Compensation documentation
- Prior impairment or disability evaluations

Contact Information

Toll Free: 844-495-HELP (4357) The Psychiatry Group
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