



# NEW PATIENT REFERRAL FORM

## Patient's Information

Full Name :

Address :

Contact Number :

Claim Number :

Date of Injury :

Social Worker/Case Manager's Name and Contact Number :

Referring AP and Reason for Referral :

Allowed DX :

Contact Person & Phone/Email for Referral :

Attorney's Name & Contact Number :

---

## Preferred Location:

Kent       Renton       Everett

Kennewick       Spokane       402 E Yakima Ave,   
Yakima, WA 98901  
(New)

Level of Urgency: (Please indicate the level of urgency using numbers (1, 2, 3, and 4), where 1 signifies the highest urgency and 4 signifies routine priority. This will help us with scheduling and prioritization.

1

2

3

4

Please fax to : 509-260-4065

Ph: 844-495-4357

Attn: Intake, The Psychiatry Group, 3131 N Division St, #201, Spokane, WA 99207