UF College of Public Health & Health Professions
UNIVERSITY of FLORIDA

# UF Psychology Clinic

## Patient Referral Form

### Referral Guidelines

1. To refer a potential patient, please complete this form and **fax** it to **352-265-0096**

### Patient Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Patient Phone #: _____

Parent Name (if pt under 18) _____

Insurance Name & Address: _____ Insurance Phone #: _____

Insurance Policy # _____ Insurance Group # _____

### Referral Information

Referring Physician Name: _____

Address: _____

Phone No: _____

NPI #: _____

Contact person phone #: _____

Why are you referring this patient to the UF Psychology Clinic:

### For UF Psychology Clinic Use Only

Date Received: _____ Received by: _____

Patient Contacted _____ Appointment Date: _____