

Patient Referral Form

Referral Guidelines

1. To refer a potential patient, please complete this form and **fax** it to **352-627-4889**

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 Health - Psychology Specialties?

For UF Health - Psychology Specialties Use Only

Date Received: _____ Received by: _____
Patient Contacted _____ Appointment Date: _____