Ruhwell MED

PSYCHIATRIC REFERRAL FORM

FAX COMPLETED FORM TO: 979-256-0764

ruhwellmed.com contact@ruhwellmed.com Phone: 979 205 5460

PATIENT INFORMATION

Patient name: **DOB:**

Phone: **Email:**

Parent/guardian, if minor: **Guardian phone:**

Insurance: **Member ID:**

Preferred contact: ○ Phone ○ Text ○ Email

REASON FOR REFERRAL

Priority: ○ Routine ○ Urgent *For urgent referrals, please also call 979-205-5460*

Reason for referral:

Relevant medical history, allergies, or safety concerns (optional):

Attach recent office note, medication list, relevant labs, and prior psychiatric records (optional).

REFERRING PROVIDER

Provider name: **Practice:**

Phone: **Date:**

Fax:

Thank you for trusting Ruhwell Med with your patient's care.

We will contact the patient or guardian to verify insurance, complete intake forms, and schedule an appointment. **Submitting this form does not confirm acceptance or establish a clinician patient relationship.**

For psychiatric emergencies or immediate safety concerns, direct the patient to 911 or the nearest emergency department.