Patient Referral Form

You can also fax the referral form to 469-814-0233

Patient Information

- **First Name:** _____
- **Last Name:** _____
- **Date of Birth (DOB):** ____ / ____ / _____
- **Phone Number:** (_____) _____ - _____

Referring Provider Information

- **Provider Name:** _____
- **Phone Number:** (_____) _____ - _____
- **Fax Number:** (_____) _____ - _____
- **Date of referral:**

Referral Details

- **Specialty Referred To (Check One):**
  ☐ Psychiatry
  ☐ Child Neurology
  ☐ Sleep Medicine
- **Reason for Referral:**

- Note:
  We will contact the patient directly and obtain prior authorization as needed.