Living Water Psychiatry, PLLC
Marjory Frederic, MSN, APRN, PMHNP-BC
(702) 854-6853
(702) 758-7315
info@livingwaterpsychiatry.com
livingwaterpsychiatry.com

Patient Referral Form

Ways to Submit This Referral Form

1. You may complete and submit this form online.

2. You may print this form by clicking **"Fill This Out By Hand"** at the top right corner, manually complete it, and fax it to:

Living Water Psychiatry

ATTN: Marjory Frederic, MSN, APRN, PMHNP-BC

Phone: (702) 854-6853

Fax: (702) 758-7315

Referring Practice/Provider/Organization Information

Name of Referring Practice/Provider/Organization

Provider Role

☐ Primary Care Provider (PCP) ☐ Therapist ☐ Other

Practice/Provider/Organization Address

Practice/Provider/Organization E-Mail Address

Practice/Provider/Organization Phone Number

Practice/Provider/Organization Fax Number

Name of Person Completing Form

Reason for Referral

☐ Psychiatric evaluation ☐ Diagnostic clarification ☐ Ongoing medication management ☐ Second Opinion
☐ Other (comment below)

Other Reason for Referral

Is the patient aware of the referral and consents to being contacted?

○ YES ○ NO

If no, please explain the reason why they are unaware and/or do not consent.

Safety / Urgency Triage

☐ Recent psychiatric hospitaliaztion ☐ Acute safety concerns ☐ Current SI/HI

☐ No current safety concerns (N/A) ☐ Other urgent clinical considerations

Explain "Other urgent clinical considerations"

Please enter the PATIENT'S information below:

Patient First Name: Patient Middle Name: Patient Last Name: Date of Birth:

Gender Assigned at Birth:
○ Female ○ Male ○ Intersex

Marital Status
○ Divorced ○ Domestic Partner ○ Married ○ Separated ○ Single ○ Widowed

Street Address Apt/Unit #

City State Zip Code

Patient Cell Phone: Patient Home Phone: Patient Work Number

Patient Email:

Preferred Contact Method
☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email

Does the patient have insurance?

○ Yes ○ No

Primary Insurance

Primary Insurance Company

Is the primary insured subscriber name and DOB someone other than the patient?

○ YES ○ NO

Primary Insurance Details

Member ID / Policy #

Group Number

Client Relationship to Insured

○ Spouse ○ Child ○ Other

Insured Name

Insured Phone #

Insured Date of Birth

Insured Sex

○ Female ○ Male

Insured Street Address

Insured City

Insured State

Zip Code

Does the patient have a secondary insurance?

○ Yes ○ No

Secondary Insurance

Secondary Insurance Company

Is the secondary insured subscriber name and DOB someone other than the patient?

○ YES ○ NO

Secondary Insurance Details

Member ID / Policy #

Group Number

Client Relationship to Insured

○ Spouse ○ Child ○ Other

Insured Name

Insured Phone #

Insured Date of Birth

Insured Sex

○ Female ○ Male

Insured Street Address

Insured City

Insured State

Zip Code

SUPPORTING DOCUMENTATION

Supporting Documentation

Please upload any documents relevant to the referral.

If you are completing the form manually offline, attach the documents to the fax and send the completed **Patient Referral Form** to:

Living Water Psychiatry

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Acknowledgement and Consent to Contact

By entering in this patient information, you acknowledge that it will be sent via secure email. You are giving us consent on the patients behalf to contact them via email, text messages, and by phone as needed. By submitting this form, you are giving us consent to this information and the ability to contact you and/or the patient.

	Date	Method of Contact	Outcome of Attempt	Name of Person Attempting Contact
First Attempt				
Second Attempt				
Third Attempt				

Comments regarding attempts

Final Referral Outcome

- ○ Scheduled
- ○ Unable to Reach
- ○ Declined Appointment
- ○ Scheduled Somewhere Else
- ○ Other

Please explain "Other"

Referring Provider Notified

- ○ Yes
- ○ No

Please click the RED SUBMIT FORM button in the lower right corner so that we receive this form.