



CLAYTOR MEMORIAL CLINIC

Outpatient Referral Form for Richard L. Claytor, Jr., MD

1625 Franklin Street, Rocky Mount, VA 24151

Phone: 540-483-0373 Fax: 877-803-9136

admin@claytorclinic.com

DATE OF REFERRAL: []

SERVICE DESIRED: [] Psychiatric Services

Chief Complaint/ Presenting Problem: []

CLIENT DEMOGRAPHIC, INSURANCE, AND DIAGNOSTIC INFORMATION
Name: []
Address: []
Home Phone: [] Date of Birth: []
Cell Phone: [] Gender: []
Work Phone: [] Race: []
Social Security Number: [] Marital Status: []

INSURANCE INFORMATION:
Medicaid Number: []
Private Insurance Name and Phone Number []
Private Insurance Behavioral Health Name and Phone Number []
Private Insurance ID and Group Number []
Private Insurance Policy Holders Name and SSN []

DIAGNOSTIC INFORMATION:
Axis I: []
Axis II: []
Axis III: []
Axis IV: []
Axis V: []

LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE/POA INFORMATION (If Applicable)
Name: [] Relationship: []
Address: []
Home Phone: [] Cell Phone: [] Work Phone: []

EMERGENCY CONTACT INFORMATION
Name: [] Relationship: []
Address: []
Home Phone: [] Cell Phone: [] Work Phone: []

CURRENT SERVICE PROVIDERS:
MHSS PROVIDER: []
PSYCHIATRIST: []
OUTPATIENT COUNSELOR: []
OTHERS: []

REFERRING PARTY NAME: [] REFERRING AGENCY: []
MAILING ADDRESS: []
TELEPHONE NUMBER: [] E-MAIL ADDRESS: []
FAX NUMBER: []

Please fax referral form to Claytor Memorial Clinic at 877-803-9136