KINSHIP

NEW PATIENT REFERRAL

Referral / Fax: (606) 203-5690

Fax completed referral and supporting records

*Kinship is currently accepting referrals for future services. **Scheduling is not yet available, and an anticipated scheduling date has not been established.** Patients will be contacted when appointments become available. Submission of a referral does not guarantee acceptance or establish a provider-patient relationship.

PATIENT INFORMATION

Name: _____ **DOB:** _____

Phone: _____ **Insurance:** _____

SERVICE REQUESTED

- ☐ Medication Management
- ☐ Therapy
- ☐ Targeted Case Management

REASON FOR REFERRAL

_____

_____

_____

CLINICAL INFORMATION

Current diagnoses: _____

Current psychiatric medications: _____

Records included:

- ☐ Office note
- ☐ Medication list
- ☐ Labs
- ☐ Other: _____

Referring Provider / Office

Provider / Practice: _____

Contact: _____ **Phone:** _____

Fax: _____ **Date:** _____

☐ Patient/referring office understands Kinship is not currently scheduling new patient appointments.