



The Wellness Office

Quratulain Agha MD, Psychiatry

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PHYSICIAN REFERRAL FORM

REFERRING DOCTOR

Doctor Name: _____

Phone: _____ Fax: _____

Address: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Phone: _____ Cell Phone: _____

Address: _____

Referral Reason: _____

Primary Insurance Company: _____

Policy No.: _____ Group No.: _____

Insured Name: _____ DOB: _____ Relationship: _____

Secondary Insurance Company: _____

Policy No.: _____ Group No.: _____

Insured Name: _____ DOB: _____ Relationship: _____

DR.AGHA DOES NOT ACCEPT MEDICAID,UHC,CIGNA, OR AMERICAN BEHAVIORAL

DR.AGHA WILL NOT ACCEPT PATIENTS ON MORE THAN 2 CONTROLLED SUBSTANCES