



9238 Madison Blvd Suite 750
Madison, AL 35758
(256)-724-8880 (p) (888)951-7515 (f)
NALFPC.com

Clinician Psychiatric Services Referral Form

CONFIDENTIAL

Provider: Anika Wilson MD, Board Certified Child, Adolescent and Adult Psychiatrist
 Michelle Pratt, CRNP, PMHNP-BC
 James Taylor, LPC
 Susan Ratliff, LPC

Date of Referral: _____

Patient Being Referred: _____

Date of Birth: _____ Age: _____ Gender M F

Parent/Legal Guardian: _____

Address: _____

Email: _____

Home Phone: _____ Cell/Work Phone: _____

Insurance: _____

Insured's Name: _____

Insured's Employer: _____

Insured's DOB: _____

Policy # _____ Group # _____

Referral Source: _____

Contact Name: _____ Contact Phone: _____

Reason for Referral:

Psychiatric History/Diagnosis/Prior Mental Health Services: ___ None

Current Medication (If Any):

Check All Items That Apply:

Family Substance Abuse ___ Physical Abuse ___ Physical Aggression ___ Homicidal
Ideation ___ Substance Abuse ___ Sexual Abuse ___ Legal Involvement ___ Suicidal
Ideation ___ Attention-Problems ___ Fire Setting ___ Oppositional/Defiant ___ Self-
Mutilation ___ Depression ___ Anxiety ___ Bipolar ___ Anger ___

Please Comment On Checked Items And Provide Any Additional Relevant Information:

Name of Person Completing Form: _____

Phone Number: _____

Signature of Patient or Parent/Legal Guardian: _____

** If unable to obtain parent/guardian signature, please note if verbal consent was given.*

Fax completed form to (888) 951-7515 Attention: NEW REFERRAL. Someone from the office will contact the patient or patient's parent to schedule an appointment as soon as possible. If you have any immediate concerns please contact the office at (256) 724-8880. Thank you for your referral.

OFFICE USE ONLY:

Appt. in computer: _____ Appt. Date/Time: _____

Website given: _____ Forms emailed: _____ Faxed: _____ (Date) _____

Account put in the computer: _____ Account Number: _____