FARRAR & ASSOCIATES
MENTAL HEALTH

3301 North Ballard Road, Suite C
Appleton, WI 54911
tel: 920.841.8326
Fax: 833.283.7571
contact@farrarmentalhealth.com

Psychiatric and/or Psychotherapy Referral Form

For consideration of care, not a guarantee of care

To be completed by: Therapist, Primary Care or OB/GYN Clinician

Referring Provider: _____

Referrer's contact number: _____

Patient Name: _____

Patient phone number(s): _____

Patient DOB: _____

Health Insurance: _____

Patient's Primary Care Provider:_____

Patient's most recent prescriber of psychiatric medications:_____

Current psychiatric medications, if any: _____

_____

Reason for Referral: _____

_____

_____

Requested Psychiatric Provider: ___Tasha Farrar, MD ___ Joelle Fellinger, APNP

Requested Psychotherapy Provider: ___ Melissa Pecor, PhD ___ Sherrie Kamm, PhD

This referral will be reviewed by one of our providers. Please be aware that should the patient's needs be better met by services elsewhere, you will be notified. Our exclusion criteria is available on our website.

Please feel free to contact us with any questions. Thank you for your referral.