FARRAR & ASSOCIATES
MENTAL HEALTH

16 Tri-Park Way
Appleton, WI 54914
tel: 920.841.8326
Fax: 833.283.7571
contact@farrarmentalhealth.com

# Psychiatric 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
- ☐ Steven Turchan, MD

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

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