FARRAR & ASSOCIATES
MENTAL HEALTH

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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
- ☐ Steven Turchan, MD

Requested Psychotherapy Provider

- ☐ Melissa Pecor, PhD
- ☐ Sherrie Kamm, PhD
- ☐ Linell Berkley, MSW, LCSW

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.