Wholesome Clinic
Psychiatric & Family Practice

PHONE: 1-844-594-6537
972-905-9435
FAX: 972-905-9489

PATIENT REFERRAL FORM

Person submitting Referral:					Agency/Facility:	
Phone:	Fax:				Date/Time:	
PATIENT INFORMATION						
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this the legal name? ❑ Yes ❑ No	If not, what is the legal name?	(Former name if applicable):	Date of Birth: / /	Age:	Sex: ❑ M ❑ F	
Street address line 1:		Social Security no (last 4 digits):		Home phone: Cell phone:		
Street address line 2:	City:		State: TX	ZIP Code:		
Reason for referral:						
Allergies:						
Medication List:						
INSURANCE INFORMATION						
Name of person responsible for bill:	Date of Birth: / /	Address (if different):		Phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No						
Primary Insurance:						
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other						
Name of secondary insurance (if applicable):	Subscriber's name:		Group #:	Policy #:		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other						
Name of Primary Care Provider/Clinic:			PCP Phone Number:			
IN CASE OF EMERGENCY						
Emergency Contact:	Relationship to patient:	Home phone: ( )	Cell phone: ( )			

Please fax this form to **972-905-9489** ***Please call 972-905-9435 to confirm urgent referrals.***
Thank you for the referral