Serenity Telemental Health

✓ Psychiatric medication management
✓ Lifestyle-based interventions
✓ Referrals accepted within 48 hours

Psychiatry Referral Form

Patient Information

Patient Name: _____

Date of Birth: _____

Phone: _____

Email: _____

Preferred Contact Method: ☐ Phone ☐ Email

Date of In-Person Evaluation (by referring provider): _____

Reason for Referral

Psychiatric evaluation and treatment for: _____

_____

_____

_____

Provider Attestation

By signing below, I attest that:

- I am a DEA-registered practitioner.
- I have personally evaluated this patient in person on the date listed above.
- I am referring this patient for psychiatric services with Serenity Telemental Health.

Referring Provider Information

Provider Name (Printed): _____

Provider Signature: _____ Date: _____

NPI Number: _____ License Number & State: _____

Phone: _____ Fax: _____

Fax completed form to **(845) 345-8923** or email form to **referral@serenitytelementalhealth.com**
If the patient consents, kindly include a copy of your evaluation for continuity of care.

SerenityTelementalHealth.com
Phone (845) 206-9715
Fax (845) 345-8923
info@serenitytelementalhealth.com