



Main Office: 378 Williamson Rd., Ste 204 Mooresville, NC 28117
Morganton Office: 404 W. Fleming Dr., Suite C, Morganton, NC 28655

Patient Referral Form

REFERRING OFFICE INFORMATION

Referring Provider: _____

Practice Name: _____

Phone: _____ Fax: _____

Address: _____

Contact Person: _____

PATIENT INFORMATION

Patient Name: _____

Parent/Guardian Name: _____

DOB: _____

Phone: _____

Email: _____

Address: _____

Please attach insurance card or complete the following:

Primary Insurance: _____

Member ID: _____ Group: _____

Subscriber Name: _____

DOB: _____ Relationship: _____

REASON FOR REFERRAL

(Check all that apply)

- Depression
- Anxiety
- Bipolar Disorder
- ADHD Evaluation/Management
- PTSD/Trauma
- Insomnia/Sleep Concerns
- Mood Instability

- Behavioral Concerns
- Medication Management
- Autism Evaluation/Referral Assistance
- Psychosis
- OCD
- Substance Use Concerns
- Spravato Evaluation
- Other:

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URGENCY OF REFERRAL

- Routine
- Urgent (please explain below)

RELEVANT RECORDS INCLUDED

- Office Notes
- Medication List
- Labs
- Imaging
- Psychological Testing
- Hospital Records
- Insurance Card
- Other:

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PATIENT CONSENT

- Patient is aware of and agrees to psychiatric referral.

Thank You!

Please return this completed form to:

Mind Fit Behavioral Health
Phone: 704-978-8334
Fax: 980-399-2600
Email: info@mindfitbh.com
Website: www.mindfitbh.com