B. Rhett Myers, M.D.
dba Upstate Psychiatry, P.A.
Hope P. Cromer, M.D.
dba Blue Ridge Psychiatry, P.A.
Anthony J. Tridico Jr., M.D.
dba Bayou Psychiatry, P.A.
John R. Dodenhoff, LISW-CP
dba Paris Mountain Psychotherapy, Inc.
Susan M. Essich-Kruse, LISW-CP
dba Kruse Psychotherapy, Inc.

Upstate Psychiatry, P.A.

All Psychiatric Services • Adult, Child, Geriatric

REFERRAL FORM

Mario E. Galvarino, M.D.
dba Piedmont Psychiatric Associates, P.A.
Jeanne C. Morrow, M.D.
dba Jeanne C. Morrow, M.D.
Pamela J. von Kleist, LISW-CP
dba Pamela J. von Kleist, LISW-CP
Briana Flesch, LISW-CP
dba Briana Flesch, LISW-CP
Harrison M. Kisner, LISW-CP
dba Mangum Behavioral Associates, P.A.

Patient Name:____

Male/Female **Race:**____________________ **Marital Status:**__________________

Date Of Birth:_________________________ **SS#:**_________________________

Address:____

City:______________________ **State:**______________ **Zip Code:**__________

Home Phone #:________________________ **Cell / Work #:**__________________

Guarantor (If patient is under the age of 18):____________________________

Insurance Company:__________________ **Benefits Phone #:**________________

ID #:_____________________________ **Group #:**_________________________

Name of Insured:____________________ **Employer:**________________________

Insured's SS #:______________________ **Insured's DOB:**___________________

****

PLEASE SEND CLINICAL INFORMATION / RECENT OFFICE NOTES WITH THIS REFERRAL.

****

Referring Doctor:______________________ **Phone #:**______________________
Address:_____________________________ **Fax #:**_________________________
UPIN:_______________________________ **Federal ID:**_____________________

To expedite referral for your staff, please fax form to us at (864)220-6109. We will call the patient and schedule the appointment. Please note that we must have complete information in order to schedule an appointment. Thank you for your referral.

Date & Time of Appointment:____

Doctor / Therapist:____