Mid Cities Psychiatry

Referral Information Form

Referring Practice/Physician

Practice Name:	Dated
Physician Name:	Work #
E-mail	Cell #
Specialty	Fax#
Add/City/	State/Zip

Referred Patient

Name			
DOB	Male □ / Female □	Under 18	Yes □ / No □
Address			
Tel #		e-mail	
Diagnosis & Reason for Referral			

Please complete following questions if applicable

Currently seeing a Psychiatrist? No □ / Yes □ (if Yes, please complete the following)

Physician Name	Work #
E-mail	Fax#
Add/City	State/Zip

Primary Care-Physician Name

Practice Name	Work #
E-mail	Fax#
Add/City/	State/Zip

Are you currently taking any medication? No □ / Yes □ (if Yes, please complete the following)

Prescribing Physician Name	
E-mail	Work #
Add/City	State/Zip

MID CITIES PSYCHIATRY
200 Westpark Way, Euless, TX 76040
office: (817) 488-8998 <> fax: (855) 295-2686
info@MidCitiesPsychiatry.com <> www.MidCitiesPsychiatry.com

Seema Kazi, MD, PA

Mid Cities Psychiatry

Recent (past 12 months) admission to any mental health facility	No □ / Yes □ (if Yes, please complete the following)
Health Facility Name	
History of Substance Abuse?	Yes □ / No □

Insurance Provider	Effective Date
Policy #	Group #
Insured's Name	DOB
Relationship	Phone #

In addition to the information listed above, please fax over a demographic sheet containing patient name, DOB, contact & insurance information. Please send over all pertinent medical records from the past 6-12 months, including a medication list

Authorization to Release Healthcare Information

This is a release form for authorization of my medical information to be transferred between health care providers, health insurance companies and any other party involved in my medical care.

I authorize _____ (name of referring facility) to release all medical information to Mid-Cities Psychiatry to better manage my health.

This request includes: hospital summaries, medication lists, laboratory reports, physician progress notes, and any other healthcare information relating to my condition.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Social Security #
Signature of Patient Representative (If Applicable)	Date

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