ARCHER ANGELS FAMILY SERVICES

Patient Referral Form

To ensure timely processing of referrals, a Physician or a Primary Care staff member working for your facility must complete all fields on this form. **Please fax back to 855-420-6895.**

PROVIDER INFORMATION

MEDICAL PROVIDER NAME:

HOSPITAL/FACILITY NAME:

FACILITY ADDRESS:

PROVIDER CONTACT PHONE #:

FAX NUMBER:

EMAIL:

PATIENT INFORMATION

NAME:

DOB:	GENDER:

ADDRESS:

PHONE NUMBER(S):	EMAIL:

PRIMARY INSURANCE CARRIER NAME:

INSURANCE MEMBER ID:

SECONDARY INSURANCE CARRIER NAME:

INSURANCE MEMBER ID:

DIAGNOSIS (DX):

MEDICATION (S):

ALLERGIES:

Please describe the reason for this referral, presenting symptoms, concerns & need areas

ARCHER ANGELS FAMILY SERVICES

Archer Angels Family Services (AAFS) is a private practice currently providing psychotherapy through telehealth distance conferencing. This practice seeks to counsel underserved individuals and families in this region. Archer Angels Family Services will refer patients for psychiatric treatment which includes evaluations, psychotropic medication/prescriptions or in-patient hospitalization. Your primary care or dental facility provides preventative, acute, and chronic primary health services to patients in Massachusetts.

Signing below will also add this Primary Care Provider to the AAFS referral network. Affiliation with this practice will support evidence-based practices to streamline and improve patient care. Patients may be directed to your facility for comprehensive medical and/or dental treatment that are not provided at AAFS. By signing below, this primary care practice certifies that patients referred for mental health services meet the criteria of medical necessity.

HOSPITAL / FACILITY/ AGENCY/SITE:	**DATE:**
PRINT PHYSICIAN NAME (or Authorized Representative):	**PHYSICIAN SIGNATURE (or Authorized Representative):**

SITE NAME: Archer Angels Family Services	**DATE:**
PRINT NAME (or Authorized Representative):	**SIGNATURE (or Authorized Representative):**