LIBERTAS MIND

Patient Referral Form

In order to refer a patient please fill out the form and send the following:

1. **Complete this page**
2. **Send a demographics sheet with insurance and contact information**
3. **Send your last treatment or encounter note**

1. PATIENT INFORMATION

First Name: _____ Last Name: _____ Date of Birth: _____

Address: _____ Phone Number*: _____

Town/City: _____ State: _____ ZIP Code: _____ Email: _____

2. MEDICAL HISTORY

Diagnosis: _____

Medical/Treatment History: _____

Medication History: _____

Upload this form to the website or fax to 518-240-4310

Include a demographics sheet showing the patient's insurance

Attach or send the last treatment or encounter note

Practice: _____ Email: _____ Fax Number: _____

Provider Name: _____ Provider Phone: _____

Please notify me with updates regarding my patient through: Phone/ Email/ Fax

Add any additional information below:

963 Route 146, Ste 1, Clifton Park, NY 12065

P - 518-672-3050
F - 518-240-4310

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