TRINITY
WELLNESS CENTER

New Patient Referral Form for ***Dr. Kimberly Adams***

A copy of both sides of the patient's insurance card must accompany this form, along with any relative office notes, labs, or documentation.

Fax to 910-343-6989

Patient Name: _____

Patient DOB: _____/_____/_____ Age*: _____ Gender: M F

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Alt Phone #: _____

If the patient is a minor (less than 18 years old), the following is required:

Legal Guardian's Name: _____

Legal Guardian's address: Same or _____

_____

Legal Guardian's Phone #: _____

Relationship to Patient: _____

Name of referring provider: _____

Referring provider's NPI #: _____

Address of referring provider: _____

Phone #: _____ Fax #: _____

REASON FOR REFERRAL (please indicate services requested):

- Psychiatric Assessment (medication evaluation and/or management)
- Psychological Assessment (ADHD, learning disability, mood disorders, Autism, etc.)
- Neurolopsychological Assessment (Memory testing, dementia, TBI, stroke)
- Other (explain):

  _____

Please fax this form, including copies of the patient's insurance card (front and back) and the Carolina Access authorization code (if applicable), to 910-343-6989. We will contact your patient regarding the referral within 48 business hours of being received with scheduling information. The providers at Trinity Wellness Center appreciate your continued trust in our mental health care for your patients.