

Referral Order

Facility Name: _____ Date: _____

Patient Name: _____ Attending Physician: _____

Lone Star Psychiatric Services c/o Allan J. McCorkle, M.D. to evaluate and treat, via face to face and/or compliant telemedicine platform.

POA/Responsible Party/Guardian _____ agrees.
(must match name in face sheet) (Print First and Last Name of Person Giving Consent)

(Patients with a diagnosis of dementia require consent from POA/Responsible Party/Guardian)

Signature of Nurse obtaining verbal order from Attending Physician / TORB / VORB:

Verbal Order Signature

Attending Physician Signature

Must fill in ALL blanks to process referral.

(May send this referral form prior to obtaining physician signature)

Is this referral initiated by the results of a Trauma Screening? (Y / N)

If yes, please send trauma screening with referral paperwork.

Do you want this patient seen on our next scheduled visit? (Y/N)

If no, please contact office to arrange for a prompt evaluation.

Scan or Fax the following documents:

- ☐ COMPLETED REFERRAL ORDER
- ☐ FACESHEET
- ☐ CURRENT WORKING/UPDATED MAR
- ☐ TRAUMA SCREEN, if yes above

lhendrick@txpsy.com

SCAN TO: OFFICE@TXPSY.COM or FAX TO: 866-622-6755

Please send once verbal order & consent are received.

Please have attending physician sign and then place this order in your order set. Thank you for your referral.