LANDMARK HEALTH SYSTEMS

GENERAL REFERRAL FORM

To refer a patient for services, please fill out this form with the patient's details and return via fax. We will then contact the patient directly to schedule an appointment.

Patient Name: _____ DOB: _____

Address: _____ City: _____ Zip Code: _____

Preferred method of contact is: (please circle one, but fill both fields out)

Telephone: _____ Email: _____

TO BE FILLED OUT BY REFERRING PROVIDER:

Reason(s) For Referral: (CIRCLE/ CHECK ALL THAT APPLY) Patient Currently:

-Full Psychiatric Evaluation	-Non-Opioid Pain Mgmt	-Takes psych meds, needs transfer of care
-Psychiatric Med Mgmt	-TMS Consultation	-Presents w/Sx, not currently in tx
-Mental Health Counseling	-Ketamine Consultation	-Requested a Referral
-Substance Abuse Eval/Mgmt	-Weight Mgmt	-Other (specify below)
-Medical Marijuana	-Other (specify below)	

If you selected "other" or would like to include details with this referral, please do so here or attach notes:

_____

_____

THIS FORM MUST BE SIGNED BY THE REFERRING PROVIDER. PLEASE INCLUDE APPROPRIATE RECORDS TO SUPPORT DIAGNOSIS AND ASSOCIATED CONDITION/SYMPTOMS:

Referring Provider Full Name: _____ Specialty: _____

Practice Site Name: _____ Telephone: _____

Address: _____ City: _____ Zip Code: _____

Provider Signature: _____

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387 FRANKLIN ST
buffalo ny 14202
716.462.0284
716.262.0481