Psychiatric Consultants, Inc.

**S. Baez, M.D.**
www.sbaezmd.com
Fax: 888-425-5869

**CLINICIAL REFERRAL FORM**

Clinician Name: _____

Contact Number: _____

HIPPA Compliant Email Address: _____

HIPPA Compliant Fax Number: _____

Client Name: _____

Client DOB: _____

Client Telephone Number: _____

Reason for the Referral:

_____

_____

_____

_____

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_____

We will contact the client and discuss appointment options.

Please encourage the visit our website for practice information, fees and policies.

Thank you for the opportunity to allow us to collaborate in the care of your patient.

You will receive a treatment plan summary via fax once the client is seen.

Dr Baez Office