iTrust Ψ Wellness Group
Psychiatric Prescribing Providers

# Referral Form

117 Commons Way Greenville, SC 29611
Tel: (864) 520-2020  Fax: (864) 640-4400
Email: referrals@itrustwellnessgroup.com

| | |
|---|---|
| **Name of Referring Provider:** | |
| Referring Provider Specialty: | |
| Practice Address: | |
| Office Telephone No: | |
| Office Fax No: | |

| | |
|---|---|
| **Full Name of Patient:** | |
| Date of Birth: | |
| Home Address: | |
| Telephone Number: | |
| **Reason for Referral** | |
| **Relevant medical history:** | |
| **Patient's primary/secondary insurance provider(s). Please provide member's ID if it is not included in a faxed chart accompanying this page:** | |

Please fax completed form to (**864) 640-4400 or email** Ashley@itrustwellnessgroup.com . Our providers will make every effort to respond to referral requests as soon as possible.

## [ OR A REFERRAL CAN BE SUBMITTED BY FAMILY MEMEBERS AND CAREGIVERS THROUGH OUR WEBSITE ]

1. Go to iTrustWellnessGroup.com

2. Click on Elderly Care Referral Form


3. All information and insurance info can be completed on this one form.