JAMIE WINDERBAUM FERNANDEZ, MD, PA

INTERVENTIONAL PSYCHIATRY OF TAMPA BAY

Clinician Referral Form

Date: _____

Patient Name: _____

Patient DOB: _____ Patient Phone: _____
Address:

_____
Insurance:

_____

Diagnosis and Reason for Referral:

_____
_____
_____

Current Medications and Doses:

_____
_____
_____

Past Medication Trials: Please provide dosages, duration and efficacy of drug trials as possible

_____
_____
_____

Referring Clinician: _____
Address:

_____
Phone: _____ Fax: _____
Email: _____

If you have any questions regarding this referral, please call 813-251-2800. Please fax the completed form to 813-251-9422 or email to jwf@interventionalpsychiatrytb.com