VPA OFFICE USE

Date: ________

Time: ________

Length: _______

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**Valley Psychiatric Associates**
**256-270-9483 Phone**
**256-325-0340 Fax**

# Referral Form for Robert Geist, Ph.D.
# Adult, Child and Adolescent Psych Testing

**Account Number** ________________________ **Date:** ____________

**Patient Name** ___________________________ **Patient DOB** _________________________

**Parent's Name**___________________________ **Phone Number** _______________________

**Ins. Contract Number** _________________________________________________________________

**Ins. Type (circle one)** **EPS** **FED** **ALL KIDS** **BlueChoice** **Other:** __________

**Referring Physician Name:** ______________________ **NPI** __________________________

**Office Phone #** ________________________________ **Fax #** _________________________

**Please list referral questions:**

**1)**__________________________ ______________________________________________________

**2)** ________________________________________________________________________________

**3)** ________________________________________________________________________________

**Additional Notes** ____________________________________________________________________

_____________________________________________________________________________________

## When Completed by Physician, Please Fax to 256-325-0340