Telehealth Referral Form

NORTH MISSISSIPPI HEALTH SERVICES
TELEHEALTH SERVICES

Please complete form and fax to clinic

Patient Full Name:_____ DOB:_____ SS#: _____

Mailing Address: _____

City:_____ State:_____ Zip Code: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Primary Insurance: _____

Secondary Insurance:_____

ATTACH COPY OF INSURANCE CARD FRONT AND BACK, MUST HAVE TO CHECK ELIGIBILITY AND PRE-CERTIFICATION

ATTACH PATIENT DEMOGRAPHIC INFORMATION, ALL RELEVANT OFFICE NOTES, LAB VALUES, CURRENT MEDICATION LIST, AND MEDICAL RECORDS WITH REFERRAL FORM

Referring Provider:_____ Clinic:_____

Referring Provider Phone #_____ Fax # _____

Explain reason for referral & additional diagnoses/symptoms: _____

_____

Please select Specialty from list below *Preferred Telehealth Site:* _____

❑ **Behavioral Health Clinic** (Fax # 662-377-7035)
Adults 18 yrs or older: ❑ Psychiatry Consult ❑ ADHD (Attach Testing) ❑ Transcranial Magnetic Stimulation
Children/Adolescents: ❑ Counseling / Therapy (Ages 5-18)
A psychiatric consultation is an evaluation by a psychiatrist to determine if the patient needs further treatment for severe psychiatric conditions or if the patient can be returned to the PCP's care with recommendations.

❑ **Diabetes Treatment Center** (Fax # 662-377-2069)
Is patient treated with: ❑ Insulin ❑ Oral Agents ❑ Insulin Pump
CHOOSE ONE: ❑ Management by DTC staff ❑ Diabetes/Nutrition Education ❑ Medical Nutrition Therapy (MNT)

❑ **Neurology Clinic** (Fax # 662-377-3716)
Is this referral for headaches? ❑ Yes ❑ No

❑ **Pulmonary Clinic Sleep Evaluation** (Fax # 662-377-6575)
Has the patient had a previous sleep study: ❑ Yes ❑ No Is the patient on CPAP or BIPAP ❑ Yes ❑ No
DME Company Name and Address:

❑ **Pain Management** (Fax # 662-377-5301)

❑ **Infectious Disease Clinic** (Fax # 662-377-5390)

❑ **Geriatrics/Dementia** (Fax # 662-377-5082)

❑ **Fragility Fracture Clinic** (Fax # 662-377-5260)

❑ **Bariatric Clinic** (Fax # 662-377-6330)

Referring clinic will be notified with appointment.