MINDPATH HEALTH

Qualifying Telemedicine Referral

If you are a patient or parent/legal guardian of a patient, please provide this form to the evaluating clinician to document the referral.

Patient name	Sex[1] ☐ M ☐ F	Gender	Date of birth

Address	Suite/Apt.

City	State	Zip code

Phone	Email address

Date of in-person medical evaluation	Referral for

Diagnosis

Evaluation & Treatment

Referred to:

Mindpath Health clinician name	National Provider Identifier (NPI)

Referred by:

Clinician name	National Provider Identifier (NPI)

Clinician signature	Phone

Please complete and fax back to:

Local Mindpath Health Office Fax Number

mindpath.com

[1] As listed with your insurance carrier. This is required for insurance verification purposes.