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	Biological Sex	Gender Identity	Date of Birth
	◯ M ◯ F	◯ M ◯ F ◯ Non-binary	

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

Referred by:

Clinician Name	National Provider Identifier

Clinician Signature	Phone

Please complete and fax back to:

Local Mindpath Health Office Fax Number

mindpath.com