

SHARMA PSYCHIATRY

VIRTUAL PSYCHIATRY SERVICES

Referral Form

PATIENT INFORMATION

Name:
PHN:
DOB:
Phone number:
Email Address:

REASON FOR REFERRAL

Please provide a small description of the patient's concerns leading to this referral: (attach additional pages if necessary)

REFERRING PHYSICIAN

Name:
PRAC ID:
Phone #:
Fax #:

CONTACT

Phone: 403-341-4303
Fax: 403-341-4322
Email:
reddeerpsych@gmail.com
Website:
SharmaPsychiatry.com

IMPORTANT NOTES

Referring physician details are mandatory

We offer Phone call and Video appointments only

We are not a crisis Mental Health service

We cannot accept referrals for patients with WCB claims, gender dysphoria or addiction/substance abuse issues or patients requiring hospitalization

We accept referrals for patients ages 6-65

Incomplete patient of physician information will result in returned referrals. Thank you for considering Sharma Psychiatry for your patient.