



**SUNSHINE
HEALTH**

Please fax completed form to:
Fax: 409.217.3976

Questions or assistance?
Phone: 409.449.1989

This form is not intended for emergencies.

For an immediate threat to life or safety, call 911 or seek emergency medical care. For mental health crisis support, call or text 988. Do not use this form to request emergency psychiatric assessment or intervention. Fields marked with an asterisk (*) are required.

REFERRAL INFORMATION

Referring Provider:* _____
(Name and credentials)

Referral Date: _____

Practice / Agency:* _____

Phone:* _____ Fax: _____

Office Email:* _____ Contact Person: _____

PATIENT INFORMATION

First Name:* _____ Last Name:* _____

Birth Date:* _____ Sex Assigned at Birth:* ☐ Male ☐ Female

Address: _____

City: _____ State: _____ ZIP _____

Cell Phone:* _____ Other Phone: _____

Email: _____ Preferred Language: _____

Parent / Legal Guardian (if under 18): _____ Phone: _____

Relationship to Patient: _____

INSURANCE INFORMATION

Sunshine Health does not currently accept all insurance plans. For the most up-to-date list of accepted insurances, visit sunshinehealthtx.com/services.

Coverage Type:* ☐ Commercial ☐ Medicaid / CHIP ☐ Medicare
☐ Tricare ☐ Self-pay ☐ Unknown

Name of Insurance Company: _____

REQUESTED REFERRAL PRIORITY:*

☐ Routine (standard scheduling) ☐ Expedited (appointment requested as soon as possible)

Requests are reviewed based on clinical need and provider availability. Expedited requests do not guarantee an appointment within a specific timeframe. This form is not monitored for emergencies.

Patient Name: _____ Birth Date: _____

Reason for Referral / Presenting Concerns*

Current Psychiatric Medications

Additional Information

Referral services requested:* (please check all that apply)

☐ Psychiatric evaluation

☐ Medication management

☐ Psychotherapy / counseling

☐ Child / adolescent assessment

☐ Psychiatric consultation / second opinion

☐ Other / unsure

If other / unsure, please describe

Preferred provider:* (please select one)

☐ Michelle Hext, DNP, APRN, CPNP-PC, FNP-C, ENP-C, PMHNP-BC

☐ Hillary Chase, MSN, APRN, PMHNP-BC, CDCES

☐ Darian Stephens, DNP, APRN, PMHNP-BC

☐ Jordan Green, MSN, APRN, FNP-C, PMHNP-BC

☐ Jessie Dotson (Peer Support Counseling)

☐ First Available Provider

Provider preferences are accommodated when possible, based on availability.

Supporting records attached (number of pages): _____

Attach any available records relevant to this referral, such as recent clinical notes, medication lists, hospital discharge summaries, or pertinent laboratory results. Please do not delay submitting a referral if supporting records are unavailable.

☐ I confirm that the patient (or their parent/legal guardian, when applicable) has been informed of this referral and agrees to be contacted by Sunshine Health regarding scheduling and care coordination.*

Referring Provider Signature: _____ Date: _____

CONFIDENTIAL: This form contains protected health information intended only for Sunshine Health. If received in error, please call 409.449.1989 and destroy all copies.