Sage Neuroscience Center

External Provider Referral Form

Date _____

Office Number _____

Referring Provider _____ Facility Name _____

Please complete this form and fax it to (505) 884-3004.
We will contact the patient within 72 hours to schedule an assessment

For hospital or inpatient discharge, medical records must be sent with this referral form for the patient to be scheduled. Were records included with this fax referral? ☐ Yes ☐ No

Patient Information

Patient Name:	Gender:	DOB:

Phone:	Alternate Phone:	SSN:

Patient Physical Address:	Will Someone else Schedule for PT? Include Name, Relation and Reason

Please make sure Patient and/or Guardian is aware of this referral and that Sage will contact them directly.

Insurance Carrier:	Name on Insurance Card:

Member ID:	Group #:	Effective Date:

Reason for Referral:

Current Medications:

Internal Sage Use Only

Assessment Date	Provider	Signature