TELEMEDICINE REFERRAL

Patient Name: _____ _____ _____

Last | First | Date of Birth (mm-dd-yyyy)

Done Health P.C. and Complete Wellness P.C. have either diagnosed and/or will be treating this person for their behavioral health condition. Due to changes in the Public Health Emergency (PHE) effective May 11, 2023, and the Ryan Haight Act, we kindly ask that you complete and sign this form to ensure uninterrupted care for our mutual patient.

In doing so, please complete the following information and acknowledge the following:

1. Based on my most recent in-person exam on_____, I clear this patient for treatment with controlled substances if needed.
2. The patient is referred to Done Health P.C. / Complete Wellness P.C. for behavioral health treatment.

If you feel there is any pertinent information to share with our prescribing providers, please include it with the submission of this form

PROVIDER NAME AND CREDENTIALS

Fill in all blanks COMPLETELY on PDF or print clearly and scan to upload.

_____ _____ _____ _____

Provider Name | State | State License | Provider DEA number

_____ _____

Practice Name | Provider NPI

_____

Practice Address

_____ _____

Practice Phone Number | Practice Fax Number

_____ _____ _____

Examination Date | Date of Attestation | Signature

When completed, send this form to your patient. You can also share it with support@donefirst.com

Done Health P.C.
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San Francisco CA 94104-5401