



1359 Milstead Road, Conyers, GA 30012

Phone: 678 562-2081 | Fax: 770 762-7899

Email: atltelepsych@gmail.com : Website: www.atlantatelepsychiatry.com

Date: April 12, 2023

Effective March 1, 2023

For all old patients and new patients of Atlanta TelePsychiatry LLC. We need your annual physical report done within the past 12 months . This could be obtained from an urgent care physician nearest to you or primary care physician. Also have the urgent care physician or primary care physician refer your mental health treatment to our clinic. Please find the attached sample of the referral letter and your annual physical report that we need in addition to result of lab work performed during the physical examination

1. Please send the result of your annual physical exam within the past 12 months with results of your most recent laboratory work and the referral letter to us as soon as possible (via email atltelepsych@gmail.com or fax to 770-762-7899)

We need you to furnish us with these requested information above in order to continue your care and prescribe your medications including any controlled substance. This is a mandatory request in accordance with the new DEA rule for Telemedicine effective as from March 1, 2023. Thanks in advance for your prompt response to this urgent request.

Olasimbo Babatope

Olasimbo M Babatope ,MD
Atlanta Telepsychiatry



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PHYSICAL EXAM

Name: _____

Date of Exam: _____ (MUST be within 1 year)

VITALS MUST BE COMPLETED

Blood Pressure: _____ Pulse: _____ Height (inches): _____ Weight(lbs): _____ BMI: _____

Normal	Check each item in the appropriate column. Enter EN if not evaluated	NOTE: Describe every abnormality in detail
	Head, Face, Neck, Scalp	
	Nose and Sinuses	
	Mouth, Teeth, Throat	
	Ears	
	Eyes	
	Ophthalmoscopic	
	Neck, Thyroid	
	Thorax and breasts	
	Lungs	
	Heart	
	Abdomen	
	Anus and rectum	

	Endocrine system	
	G.U. system	
	Upper Extremities	
	Lower Extremities	
	Feet	
	Spine	
	Neurologic	
	Skin	
	Lymphatic system	
	Vascular system	
	Other:	

Is this patient receiving or does he/she require continuing medical care, therapy or observation?

If YES, please explain (include notation of medication and dosages and plans concerning illness such as heart disease, asthma, diabetes, seizure disorders, etc.)

Does this patient have any life-threatening allergies? Yes _____ No _____

_____ (If yes, please send allergic response and suggested treatment)

I hereby declare that the above named patient is medically cleared to receive psychiatry services at Atlanta Telepsychiatry. YES _____ No _____

HEALTH CARE PROVIDER

Name: _____

Phone: _____

Address: _____

Signature: _____

Date: _____



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REFERRAL LETTER

Name of Practice: _____

Address of Practice: _____

Telephone of Practice: _____

Fax number of Practice: _____

Date of referral: _____

Patient Name: _____

Patient Date Of Birth: _____

To whom it may concern,

I am requesting that my patient name _____
have mental health treatment with a specialist.

I am referring her to:

Olasimbo Babatope, MD

NPI: 1528126539

Atlanta Telepsychiatry, LLC

1359 Milstead Rd NE

Suite 105

Conyers, GA 30012

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