Referral Form~ Fax to 877-855-2504

Please fax this form and we will contact the patient to schedule as soon as possible!

Referring Physician/Provider: ______________________ Phone:_______________

Patient Name: ____________________________________DOB:_________________

Patient's Phone:________________________ Other Contact Info:________________

Insurance:____

Please check the box or boxes for type of referral:

❑ Individual Therapy

❑ Family Therapy

❑ Child & Adolescent Therapy

Please check areas you are suggesting assessment or treatment:

❑ General mental health/diagnosis

❑ ADHD/ADD

❑ Mood and personality

❑ Behavioral functioning

❑ Chemical Health/Use

❑ Other: ____

Reason for referral and other information:

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