REFERRAL FORM

Patient Information

Date of Request: ____________________________

____
First Name | Last Name | Preferred Name

____
Street Address | City/State | Zip Code

____
Main Phone ☐ cell ☐ landline | Email Address

____
DOB | Insurance Plan/ID # (Please provide copy of insurance card)

Services Requested: (Check all that apply)

- ☐ Medication Management
- ☐ Evaluate and Treat
- ☐ Evaluate and Report Findings
- ☐ Non-urgent Request
- ☐ Expedited Request

Clinical Information:

Diagnosis with ICD-10: ____

Please attach the following, if available:

- Current PHQ-9, HAM-D, QIDS-SR, or MDRS Depression Scale Score
- Summary of patient's treatment history and medication list

Comments: ____

____

How would you prefer to receive communication on your patient's progress?

Email: ____

Only HIPAA compliant emails can be used

Phone: ______________________________ Fax: ______________________________

Referring Organization: ____

Referring Provider Name: ____

Provider Signature: ____

6400 SE Lake Rd, Suite 135	**Portland**, OR 97222	P: 971.430.2335	F: 888.850.5616
16100 NW Cornell Rd, Suite 170	**Beaverton**, OR 97006	P: 971.405.9545	F: 888.850.5616
2255 NW Shevlin Park Rd, Suite 120	**Bend**, OR 97703	P: 541.241.2509	F: 888.850.5616
330 E Mill Plain Blvd, Suite 401	**Vancouver**, WA 98660	P: 888-830-6088	F: 888.850.5616