Referral Form

Referring Provider Information:
Name of Referring Physician or Health Care Provider:
____
Office Contact: ____________________________
Phone: _____________ Fax: ____________ Email: _____________________

Patient Information:
Last Name: __________________ First Name: __________________ Middle Name: _______________
Preferred Name: ____________________
Date of Birth: _______________ Gender: Male / Female / Not Indicated / Other: _______________
Parent/Legal Guardian Contact (if patient is a minor): _________________________
Phone Number: ______________ Secondary Phone Number: _____________ Email: ________________________
Address: ____________________________________ City: ________________ State: _______ Zip Code: _______________

Insurance Information:

Primary Insurance:
Name of Insured: _______________
Insured DOB: _______________
Relationship to Patient: _______________
Policy Number: _______________
Group Number: _______________

Secondary Insurance:
Name of Insured: _______________
Insured DOB: _______________
Relationship to Patient: _______________
Policy Number: _______________
Group Number: _______________

(If Medicaid: A current Medicaid Referral must be received before the person can be scheduled. Thank you.)

Reason for Referral:

Are there any specific requests or specific clinical questions you would like for us to answer?

Requested Provider:
☐ Katie C. Lewallen, Ph.D. ☐ W. Jeff Bryson, Ph.D. ☐ Sarah R. McCoy, Ph.D.
☐ Megan D. Caudle, M.Ed., LPC-S ☐ Scott Kincaid, LPC-S, NCC ☐ Amy C. Bryan, LPC
☐ No Preference. Please assign this person to the next available provider that can meet this person's needs.

Please include any pertinent medical records. This may include recent notes, recent psychological assessments, recent academic assessments, EEG reports, MRI reports, CT reports, PSG reports, etc. **Please fax this form to 256-517-8355**

Thank you for your referral and trusting Alliance Behavioral Health, LLC with the extended care of this person.