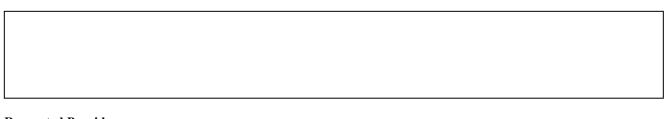
Referral Form



	cian or Health Care Provi				
Office Contact:					
Phone:	Fax:	Email:			
Patient Information:					
Last Name:	First Name:		Middle Name:		
Preferred Name:					
Date of Birth:	Gender: Male / F				
	ontact (if patient is a mind				
Phone Number:	Secondary Pho	ne Number:	Email:		
Address:		City:	State:	Zip Code:	
Insurance Information: Primary Insurance: Name of Insured: Insured DOB: Relationship to Patient: _ Policy Number: Group Number:		nsured DOB: Relationship to Pa Policy Number:		-	
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-SScott Kincaid, LPC-S, NCCAmy C. Bryan, LPCIantha Calloway, LPCDawn M. Jordan, LPCHaley Callahan, ALCNo Preference. Please assign this person to the next available provider that can meet this person's needs.Sarah R. McCoy, Ph.D.

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. <u>Please fax this form to 256-517-8355</u>

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

Alliance Behavioral Health, LLC – Crestwood Professional Center, 250 Chateau Drive, Suite 145, Huntsville, AL 35801 Phone: 256-801-8937 – Fax: 256-517-8355 – staff@alliancehsv.com – alliancehsv.com