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: _____

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
- ☐ Iantha Calloway, LPC
- ☐ Dawn M. Jordan, LPC
- ☐ Haley Callahan, ALC
- ☐ 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.

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