Referral Form

Referral From: _____

Referral To:

☐ Katie Lewallen, Ph.D. ☐ W. Jeff Bryson, Ph.D. ☐ Sarah McCoy, Ph.D.
☐ Dawn Jordan, LPC ☐ Haley Callahan, LPC ☐ Geraldine Thompson, LICSW
☐ Paula Chandler, LPC ☐ Miranda Turney, LPC ☐ Della Nix, LICSW

Office Contact: _____

Phone: _____ Fax: _____ E-mail: _____

Patient Information

First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____ DOB: ____/____/_____ Gender: M / F / Other

Phone Number: _____ E-mail: _____

Address: _____ City _____ St: _____ Zip: _____

Contact Person (if pt is a minor): _____ Relation: _____

Insurance:

Primary: _____ Secondary: _____

Member ID: _____ Member ID: _____

Group #: _____ Group #: _____

Policy Holder Information:

Name: _____

DOB: _____

Relation: _____

Policy Holder Information:

Name: _____

DOB: _____

Relation: _____

Reason for Referral:

☐Psychological/Neuropsychological Testing ☐Treatment ☐Counseling ☐ ADHD Coaching

Additional Information: _____

Please include supporting documentation such as clinical summaries and previous evaluation reports.

Please note that we do not provide medication management services.

Alliance Behavioral Health, LLC
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