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, LPC

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
250 Chateau Drive Suite 145 |Huntsville, AL 35801
P: (256) 801-8937 | F: (256)517-8355
staff@alliancehsv.com