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| **Fax Referral Form** Please fax to: 937-275-1555 Dayton/Mental Health/AOD 740-479-5196 Ironton/Mental Health/AOD 740-776-2793 Wheelersburg/Mental Health 740-353-1113 Portsmouth/AOD |

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| --- |
| **Patient Details DATE** |
| Name Male / Female |
| Parent/Guardian Name Relationship To Patient |
| Address City County State Zip |
| Telephone Number Emergency Contact Telephone NumberHome Cell Work |
| Marital Status Date Of Birth Age |
| REFFERED BY |

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| DIAGNOISIS/REASON FOR REFERRAL |

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| TYPE OF INSURANCE (We accept Ohio Medicaid and all Medicaid Plans: Caresource, Buckeye, Molina, United, Aetna, etc.) |

**We will call the client and schedule an appointment and fax information back to you.**

(Please provide the information below)

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| Telephone Number  |
| Fax Number  |
| Office Use Only;Appointment Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Appointment With:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Appointment Time for Diagnostic Assessment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |