Integrated Behavioral Health
400 Poydras Sreet, Suite 1780
New Orleans, LA 70130
(O) 504-322-3837 (F) 504-322-3847

PATIENT REFERRAL FORM

Date:_____

Referring Patient To: _____

Patient Name:_____

Patient Address:_____

Patient DOB:_____ **Patient Phone Number:**_____

Reason for Referral:_____

_____

_____

_____

Any History of Substance Use or Addiction: Yes_____ No_____

Any Special Care Needs: Yes_____ No_____

Medical History:_____

_____

Patient Records and Insurance Info Attached: Yes_____ No_____

Referring Physician Name:_____

Referring Physician Phone #:_____ **Fax #**_____

Signature:_____