



Ptarmigan Connections
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REFERRAL FORM

*Please provide as much of the following information as possible.
 Please let your patient know we will contact them within 2 weeks.*

<i>Date of referral:</i>	
<i>Patient last name:</i>	<i>First:</i> <i>MI:</i>
<i>Date of birth:</i>	<i>Gender:</i>
<i>Parent/guardian name:</i>	<i>Best contact phone(s):</i>
<i>Address:</i>	<i>Insurance Plan:</i> <i>Policy #:</i> <i>Policy holder name:</i>
<i>Referral Question</i> <i>Please describe specific problems/symptoms and diagnoses:</i>	<i>Category of Request (Check all that apply):</i> <input type="checkbox"/> <i>High Risk/ Complexity Case Consultations</i> <input type="checkbox"/> <i>Fetal Alcohol Spectrum Disorders (FASD) Diagnostic Evaluations</i> <input type="checkbox"/> <i>Autism Evaluations</i> <input type="checkbox"/> <i>Psychological and Neuropsychological Evaluations</i> <input type="checkbox"/> <i>Psychiatric Medication Management</i> <input type="checkbox"/> <i>Behavioral Health Counseling</i> <input type="checkbox"/> <i>Group Therapy</i> <input type="checkbox"/> <i>Speech and Language Therapy</i> <input type="checkbox"/> <i>Feeding and Swallowing Management</i> <input type="checkbox"/> <i>Other: _____</i>
<i>Previous/current relevant health or mental health history (include duration of symptoms):</i>	
<i>ICD-10 Code(s) (for insurance prior authorization):</i>	
<i>Does the patient have any of the following limitations: (check)</i> <input type="checkbox"/> <i>Communication</i> <input type="checkbox"/> <i>Language</i> <input type="checkbox"/> <i>Vision</i> <input type="checkbox"/> <i>Hearing</i> <input type="checkbox"/> <i>Physical Disability</i> <input type="checkbox"/> <i>History of Head Injury</i>	
<i>Requesting provider:</i>	<input type="checkbox"/> <i>Primary Care Provider</i> <input type="checkbox"/> <i>Other</i>
<i>Best contact number: 907-357-4543</i>	<i>Fax: 907-357-4533</i>
<i>Referring Provider Signature:</i>	
<i>Today's Date:</i>	

***Please send any recent chart notes, history and physical reports, or discharge summaries.