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.

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

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