liftwell

PROVIDER REFERRAL FORM

C/O: Jasmine Vega | Tel: (203) 908-5603 | Fax to: (203) 349-5441

Date of Referral: _____

Provider Name & Credential: _____

Patient Full Name: _____

Patient DOB & Age: _____

Patient Diagnosis: _____

Reason for Referral: _____

_____

Level of care being referred to (Circle One):

Outpatient Psychotherapy | Outpatient Medication Management | Neuropsychological Testing | Nutrition Services | DBT Group | EMDR Therapy | RO-DBT | Eating Disorder Treatment | Adolescent Intensive Outpatient Program | Adolescent Partial Hospitalization Program | Adult Intensive Outpatient Program | Adult Partial Hospitalization Program | Other

Best Contact Number for Patient / Parent or Guardian:

_____

Thank you for your partnership. We take great pride in our referral partnerships and collaborate to provide seamless transitions to higher level of care - back to referent. For feedback or prompt assistance: jvega@liftwellhealth.com, or mary@liftupwellness.com.