Burrell Forward

Advancing, Expanding and Improving Behavioral Health and Wellness.

Physician Referral Form

Referring Physician Information

Referring Physician

Practice Name

Address

City

State

Zip Code

Phone

Fax

E-mail

Patient Information

Patient Name

Date of Birth

Address

City

State

Zip Code

Phone

Alternate Phone

Patient E-mail

Parent or Guardian Name (if applicable)

Relationship

Patient Primary Insurance

Patient Secondary Insurance

Referral Information

Service Requested

- ☐ Therapy
- ☐ Psychological Evaluation/Testing
- ☐ Case Management
- ☐ Substance Use Treatment
- ☐ Medication Evaluation and Stabilization*

Other

Current Mental Health Concerns/Symptoms

I agree to resume medical management of mental health condition, upon stabilization.* ☐

Clinical Documentation Included ☐
(examples include: office notes, lab work, medication list, etc.)

I have discussed this mental health referral with patient/ family, and they are willing to participate in treatment. ☐

Physician Signature (required):

A scheduling representative will work with your patient to coordinate the appointment. You will receive confirmation once the appointment is scheduled. If you wish to speak to a Scheduling Representative, please call **417.761.5210**.

Please fax or e-mail all documentation to the Burrell Scheduling Office

Fax: 417.761.5211
E-mail: SWScheduling@BurrellCenter.com