REFERRAL FORM

HEARTLAND
BEHAVIORAL HEALTH

PHONE NUMBER **417-448-5664**

FAX NUMBER **417-720-2504**

EMAIL **Michelle.Buck@uhsinc.com**

Referring Agency Information

Referring Agency/Practice ______________________________	**Referring Agency/Practice** ______________________________
Phone ________________ **Fax**______________	**E-mail**________________________________
Preferred Method of Contact________________	

Patient Information

Patient Name______________________________	**E-mail**______________________________
Address________________________________	**City**____________________ **State**__________
Zip Code_________ **Phone Number**________________	**Alternate Phone**________________________
Parent or Guardian Name________________________	**Relationship**____________________________
Patient Primary Insurance______________________	**Secondary Insurance**______________________

Referral Information

Service Requested

___________ Outpatient Therapy

___________ Psychiatric Medication Consult

___________ Psychiatric Medication Evaluation and Stabilization

Current Mental Health Symptoms/Concerns

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Clinical Documentation Included____

(Office Notes, Lab Work, Medication List, etc.)

Our Heartland Outpatient Clinic Team will work with patient to coordinate the appointment. If you wish to speak to a scheduling representative, please call ***417-448-5664***

PLEASE SEND THIS DOCUMENT AND CLINICAL DOCUMENTATION (if included) TO:

E-MAIL: Michelle.Buck@uhsinc.com or FAX: 417-720-2504