PSYCHIATRIC MEDICATION MANAGEMENT

HEARTLAND
BEHAVIORAL HEALTH
OUTPATIENT CLINIC

REFERRAL FORM

Phone Number: 417-448-5664
Fax Number: 417-720-2504
Email: Patricia.Cook2@uhsinc.com

REFERRING AGENCY INFORMATION

Referring Agency/Practice

Referring Provider Name

Phone Number _____ **Fax** _____

Email _____ **Preferred Method of Contact** _____

PATIENT INFORMATION

Patient Name _____ **Gender** ☐ Male ☐ Female

Date Of Birth _____ **Parent/Guardian Name** _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Phone Number _____ **Alternate Phone Number** _____

Parent/Guardian Email Address _____

Patient Primary Insurance _____ **Secondary Insurance** _____

Primary Policy Holder _____ **Secondary Policy Holder** _____

CURRENT MENTAL HEALTH SYMPTOMS/CONCERNS

Clinical Documentation Included ☐ Office Notes ☐ Lab Work ☐ Medication List

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

PLEASE SEND THIS DOCUMENT AND ANY CLINICAL DOCMENTATION AVAILABLE TO:
EMAIL: PATRICIA.COOK2@UHSINC.COM or FAX: 417-720-2507

Heartland Behavioral Health Outpatient Clinic
1500 West Ashland Street, Nevada, MO 64772
www.heartlandbehavioral.com