FRONTIER HEALTH AND WELLNESS

Individual Therapy Services

Patient Referral Form

Fax completed form as well as the requested clinical documentation to **855-719-0457.**

Attn: Intake

Date		
Referring Provider Name	NPI	
Practice/Clinic Name	Phone	Fax
Address		

Patient Full Legal Name (First, Middle Initial, Last)	Date of Birth	Age
Patient Preferred Phone Number	Preferred Pronoun	Sex

Guardianship (If guardianship is anything other than shared or 50/50 please provide custody agreement if available)

Parent/Guardian Name (1): Guardian listed above guardianship status: ☐ Shared ☐ Primary ☐ Sole	Parent/Guardian Name (2): Guardian listed above guardianship status: ☐ Shared ☐ Primary ☐ Sole
Phone Number	Phone Number

We Do Not Bill/Accept Denali KidCare, Medicaid or Medicare

This section is not needed if there are clear copies of the patient's insurance cards sent in the referral packet

Primary Insurance Carrier	Subscribers Name	
Policy Number/Member ID	Group Number	
Patients Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4
Secondary Insurance Carrier	Subscribers Name	
Policy Number/Member ID	Group Number	
Patients Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4

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Please Select the Reason for the Referral:

- ☐ Symptom Diagnosis
- ☐ Life Changes/Transitions
- ☐ Change in Behavior/Behavioral Instability
- ☐ Trauma

Please identify the primary diagnosis or suspected diagnosis that led to this referral:

- ☐ Anxiety
- ☐ Panic/Panic Attacks
- ☐ Obsessive thoughts/actions
- ☐ Psychosis
- ☐ Suicidality/Self Harm
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Irritability
- ☐ Destructive behavior
- ☐ Personality Disorder
- ☐ PTSD/Trauma
- ☐ Sleep Disturbances/Insomnia
- ☐ Hyperactivity
- ☐ ADHD
- ☐ Focus/Concentration
- ☐ Other:

____

Is the patient currently receiving care from any of the following?

- ☐ Psychiatric Services/Med Mgmt.
- ☐ Neuropsychiatric Evaluation
- ☐ Occupational Therapy
- ☐ Couples/Family Therapy
- ☐ Speech Therapy

Is the patient currently at risk for hospitalization due to severity of psychiatric symptoms? ☐ Yes ☐ No ☐ Other

Please Explain____

Please include the following documentation with the referral

- ☐ History and Physical
- ☐ Copy of Patient Insurance and ID
- ☐ Last 5 Clinical Notes
- ☐ Discharge Summary (if applicable)
- ☐ Patient Demographic Sheet
- ☐ Intake Assessment/Evaluation

Signature of Referring Clinician:_____________________ Date:______________________________

For more information or with any questions, call 907-222-6606

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07/2022