
To Make a Referral, Please Complete Top Portion and Fax.

Date: _____ () Initial () Follow-up

Referring Physician Name: _____

Practice Name: _____

Fax: (____) _____ Phone: (____) _____

Patient's Name: _____ DOB: _____

Patient's Medicaid #: _____

Parent's Name (if minor): _____

Phone Number(s): _____

Address: _____

Reason(s) for Referral: _____

Referring Physician's Signature

Licensed Independent Practitioner's Report

Date(s) Patient Seen: _____

- () Patient did not make appointment.
() Patient made an appointment but did not keep appointment.
() Patient not seen within 60 days.

Initial Diagnoses:

1. _____ 2. _____

Recommendations: _____

Follow-up Arranged or Provided by C&B: () Further diagnostic testing _____ () Individual psychotherapy () Family psychotherapy () Group psychology () Return visit _____	Other Care Needed: () Medication management () Referrals recommended () Follow-up recommended () Lab tests () Other: _____
---	---

Signature _____

Date _____

Name _____

Title _____