*O*ptima Behavioral Health, Inc.

REFERRAL FORM

INCOMPLETE, INACCURATE, OR ILLEGIBLE INFORMATION MAY RESULT IN A DELAY OR REJECTION OF REFERRAL. PLEASE ALLOW 7-10 (BUSINESS) DAYS FOR OUR OFFICE TO CONTACT YOU OR YOUR PATIENT.

PATIENT INFORMATION		
Patient Name:		
DOB:	/ /	
Phone #:	( )	
Insurance Information:	**PLEASE FAX A COPY OF THE INSURANCE CARD AND A COPY OF THE FACESHEET**	
Previous Hospitalizations:	**PLEASE FAX ALL PREVIOUS HOSPITAL RECORDS REQUIRED BEFORE SCHEDULING**	**N/A ☐**
Previous Medications:	**PLEASE LIST ALL PREVIOUS & CURRENT MEDICATIONS FOR THE LAST ROLLING CALENDAR YEAR**	**N/A ☐**

REFERRAL INFORMATION	
Referring Provider:	
Contact #:	**Phone:** ( ) **Fax:** ( )
Comments:	**INCLUDE CLINICAL REASON FOR SCHEDULING + INCLUDE THE LAST 3 PROGRESS NOTES**

NOTICE: *We are NOT accepting:*

- **Any court probations or orders**
- **Disability (SSA/D, FMLA, STD/LTD, LOA, etc.)**
- **Substance Abuse**

PLEASE SPECIFY WHICH PROVIDER YOU PREFER YOUR PATIENT TO BE SCHEDULED WITH

PSYCHIATRIST No ☐ First Available ☐ Specific Provider (circle below, not a guarantee):

STEVEN SCHNEIR, MD	CONNIE HIRSH, MD	MICHAEL TICHY, CNP	JENNIFER HUGHES, CNP	EMILY WALTERS, CNP	NANCY PALNIK, CNP

THERAPIST No ☐ First Available ☐ Specific Provider (circle below, not a guarantee):

D. SCHNEIR	L. BAKER	G. BYERS	D. SHERMAN	K. FULLER	V. SPOHN	D. CONN	C. THORPE	ANYONE ON PLAN

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