**McDowell Healing Arts Center, LLC**
3323 Shattuck Rd, Suite 1, Saginaw, MI 48603
2387 S. Linden Rd., Suite 138, Flint, MI 48532
3722 South Straits Highway, Suite B, Indian River, MI 49749
OFFICE (989) 475-4171 FAX (989) 393-6021

# REFERRAL FORM FROM A MEDICAL PROVIDER

***Mental & Behavioral Health Counseling for Children, Teens, Adults, Families, & Couples***

**Referring Office/Physician:** ____________________________________________________________

**Client Name:** ___________________________________________________________________________

**Address:** ______________________________________________________________________________

**D.O.B**____________________ **Age:** ________________ **Sex:** ____________________

**Responsible Party:** ___________________________________________________________________

**Relationship:** ______________________________ **Telephone#:**_________________________________

**Primary Care Physician:** ______________________________________________________________

**Insurance:** _____________________________________________________________________________

**Contract#:** _______________________________ **Group #:** ____________________________________

**Policy Holder:** _________________________________________________________________________

**Policy holder D.O.B:** _________________________ **Employer:** _________________________________

**Medical Problems:** __________________________ **Substance Abuse:** ___________________________

**Recent Hospitalization: When? Where?** _________________________________________________

**Previous Mental Health Treatment: When? Where?** ______________________________________

**Current Medications:** ________________________________________________________________

**Present Problems/Symptoms:** __________________________________________________________

**Any additional Information :**

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

*This form can be either emailed to a secured email to be retrieved by our staff at admin@mhacenter.com or faxed via a secured fax at (989) 393-6021. *

Referred patients are always called within 24 business hours, after received fax or email, in order to schedule an intake appointment.