Physician Referral Form
Fax to 618-209-1474

RX MUST INCLUDE:
“EVALUATE AND TREAT” FOR SPECIFIED THERAPY
DATE, WRITTEN DIAGNOSIS, ICD-10 CODE, AND D.O.B. OF PATIENT
SIGNATURE BY MEDICAID CREDENTIALED PROVIDER FOR PATIENTS WITH MEDICAID
RX MUST BE INCLUDED WITH THE ATTACHED REFERRAL FORM TO AVOID DELAY IN SERVICES

Client Information:

Name: ____
Last First Middle Initial

Date of Birth: ___________ Age: _______

Parent / Guardian (if under 18): _____________________________________

Full Address: ____

Preferred Phone: ____________________ Okay to Leave Message: Y / N

Secondary Phone: __________________ Okay to Leave Message: Y / N

Email Address: ______________________________________ (Email-based communication may not be confidential / HIPAA compliant)

Referring Professional:

____
Last First Middle Initial

Address: ____

Phone Number: __________________ Fax Number:__________________

Diagnosis: ____

Reason for Referral: ____

□ Evaluate □ Treat

_____________________________ _____________
Physician Signature Date