ONE
BEHAVIORAL

PATIENT REFERRAL FORM

Patient Name: _____ _____ _____

Last | First | Date of Birth (mm-dd-yyyy)

One Behavioral and/or _____ have either diagnosed and/or are treating this person in the future for their behavioral health condition. With the changes to the Public Health Emergency (PHE) and the Ryan Haight Act, we are asking you to complete and sign this form so that we can provide uninterrupted care to our mutual patient.

In doing so, please complete the following information and acknowledge the following:

1. Based on my most recent in-patient exam, I clear this patient for treatment with controlled substances if needed. (date of last exam optional): _____

2. The patient is referred to _____ for behavioral health treatment

If you feel there is any pertinent information to share with our prescribing providers, please include it with the submission of this form.

PROVIDER NAME AND CREDENTIALS

Fill in all blanks COMPLETELY using a black or blue pen. Please print clearly.

Provider Name & Credentials _____

Provider NPI _____

Practice Name _____

DEA Number _____

Practice Phone Name _____

Practice Address _____

Practice Fax Number _____

_____ _____

Signature | Date

Corporate Office: 104 Whispering Pines Ave Friendswood, TX 77546

When completed, send this form to contact@texasbehavioral.com or fax it to 877-255-0161