Referral & Consent

Email Referrals To: info@elevatehealthcare.us
Call: 1-800-379-8150 Fax: 1-800-439-0805

CLIENT INFORMATION ☐ Child (5-12 yrs) ☐ Adolescent (13-17yrs)

Client Name: ____ Date of Birth: ___________

Parent/Guardian (If Applicable): ___________________ Phone#: ___________________________

Insurance Provider: ______________________Subscribers Name: __________________________

Member ID / Group ID: ____

Language Spoken ☐ English ☐ Spanish ☐ Other: ___________________________________

Recommendations for the Following Service (s)
☐ Initial Assessment ☐ Partial Hospitalization ☐ Intensive Outpatient Programming
Group programming includes Individual Therapy, Family Therapy, and Medication Management part of programming.

Diagnosis/Concerns:____

CONSENT ****** PLEASE COMPLETE THIS SECTION******

Client's Release of Information: I authorize referral source to communicate with Elevate Healthcare for the purpose of tele screening, communication, and scheduling my appointment. A authorization to release protected health information form will be required to discuss treatment. I am aware that any missed appointments scheduled will be communicated with referring physician or referral source.
Client Signature: _____________________________________ Date: ___________________
☐ Please check box if client provided verbal consent.

Referral Source Information ☐ ISD ☐ Court ☐ Provider

Person Making Referral: ____

Referral Organization: ______________________________Phone#__________________________

Office Contact Person: ______________________________ Fax# ___________________________

Email: ____

ELEVATE HEALTHCARE USE ONLY

Appointment Scheduled: Date: ___________________ Time: _____________

Client Unable / Declined to schedule: Reason: ____

Note: ____

Elevate Healthcare team member completing this document: ______________________________