

REFERRAL - CHECKLIST FORM

PLEASE FAX REFERRAL CHECKLIST AND REQUIRED FORMS TO (916) 669-1213

APPOINTMENT REQUESTED:

- Therapy
- Medication Management

Complete the following if patient has a prescription for controlled substances and/or long acting injectables.

Controlled Substances (<i>PCP contact information</i>)	Long Acting Injectable Rx (<i>Pharmacy information</i>)
<i>Name:</i>	<i>Name:</i>
<i>Phone:</i>	<i>Phone:</i>

REQUIRED FORMS:

- Completed Patient Consent form
- Completed ROI for HLN

Patient Name:	
DOB:	
Phone Number:	
Email Address:	
Address:	
Insurance Carrier:	
Insurance Subscriber ID#:	
Anticipated Discharge Date*:	
Social Worker (SW):	
SW's phone & email address:	
Special instructions:	

**If anticipated discharge date changes, please contact HealthLinkNow.*

***REFERRALS SENT AFTER 3:30PM WILL BE PROCESSED THE FOLLOWING BUSINESS DAY.
IF YOU HAVE QUESTIONS, PLEASE CONTACT HEALTHLINKNOW AT (916) 669-1200.***