HealthLinkNow

REFERRAL - CHECKLIST FORM

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

REFFERING DEPARTMENT

☐ Intake ☐ Inpatient ☐ Outpatient ☐ Confirmed Telemedicine Capabilities

APPOINTMENT REQUESTED:

☐ Therapy ☐ Medication Management ☐ Group Therapy

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

Controlled Substances (*PCP contact information*)	Long Acting Injectable Rx (*Pharmacy information*)
Name:	*Name:*
Phone:	*Phone:*

REQUIRED FORMS:

☐ Completed Patient Consent forms
☐ FaceSheet
☐ Call Sheet and/or LOC Assessment (For Intake Dept)

Patient Name:	
DOB:	
Phone Number:	
Email Address:	
Address:	
Insurance Carrier:	
Insurance Subscriber ID#:	
Anticipated Discharge Date*:	
Referring Clinician:	
Referring Clinician phone & email address:	
Special instructions:	

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

REFERRALS SENT AFTER 3:30PM (PST) WILL BE PROCESSED THE FOLLOWING BUSINESS DAY. IF YOU HAVE QUESTIONS, PLEASE CONTACT HEALTHLINKNOW AT (888) 880-8443.