Northwest ADHD Treatment Center
Patient Referral Form

Referring Provider's Name:_____ Phone: _____

Organization: _____

Patient First Name: _____Patient Last Name:_____

Patient DOB:_____Patient Phone Number:_____

Contact Name (if different from patient): _____Contact Relation: _____

Patient Email Address:_____

Patient Address_____

Insurance ID Number:_____Name of Subscriber:_____

Insurance Provider:_____Subscriber's DOB:_____

Which office are you referring this patient to (check all that apply):

- ❑ East Portland: *PO BOX 16308, Portland, OR 97292*
- ❑ Downtown Portland: *1201 SW 12th Ave Suite 224, Portland, OR 97205*
- ❑ Tualatin: *18840 SW Boones Ferry Rd #208, Tualatin, OR 97062*

What services are you referring this patient for (please check all that apply):

- ❑ Diagnostic Confirmation
- ❑ Evaluation
- ❑ Therapy
- ❑ Medication management *(Please note, for medication management **only**, additional requirements must be met: 1) A previous diagnosis of ADHD. 2) Records required from their diagnosis. 3) Records of the last two years from their most recent mental health and primary care providers.*

Has this patient been diagnosed with anything mental health related? If yes, please list all mental health diagnosis and when diagnosis was given:

_____

_____

Has this patient been diagnosed with an eating disorder? If yes, please provide the name of the disorder, diagnosis date, and current status of care i.e active problem, well maintained, in remission etc.

_____

_____

Please provide any additional information regarding this patient on the back of this form or by sending chart notes via fax to our Intake Coordinator at (503)206-6713. For questions regarding referrals please reach out to our Intake Coordinator by phone at (503)255-2343 (press 6).