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: *10011 SE Division St #203, Portland, OR 97266*

❏ Downtown Portland: *1201 SW 12th Ave Suite 224, Portland, OR 97205*

❏ West Portland: *12570 SW 69th Ave, Suite 200, Tigard, OR 97223*

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

❏ *ADHD Evaluation only*

❏ *ADHD Evaluation and continued treatment recommendations*

Services outside of an evaluation will be determined on a case by case basis after an evaluation has been completed. Evaluation does not guarantee further services.

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

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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.

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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)-454-0763. For questions regarding referrals please reach out to our Intake Coordinator by phone at (503)-427-2394 (press 6).