



# Northwest ADHD Treatment Center Patient Referral Form

Referring Provider's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Organization: \_\_\_\_\_

Patient First Name: \_\_\_\_\_ Patient Last Name: \_\_\_\_\_  
Patient DOB: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_  
Gender/Pronoun: \_\_\_\_\_ Patient Email Address: \_\_\_\_\_  
Contact Name (if different from patient): \_\_\_\_\_ Contact Relation: \_\_\_\_\_  
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

Which new patient service are you referring this patient for:

- ADHD Evaluation with therapist
- Pediatric Medication Assessment & Management with Nurse Practitioner (Ages 5-12)

*Services outside of an ADHD Evaluation with a therapist will be determined on a case by case basis after an evaluation has been completed. Evaluation does not guarantee further services. For Medication Assessments we will need 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

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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).