



Northwest ADHD Treatment Center Patient Referral Form

Referring Provider's Name: _____ Phone: _____
Organization: _____ Ext: _____

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: _____

At which office would this patient prefer to access services?

- 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

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.

Has this patient been diagnosed with anything mental health related? If yes, please list all

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