Northwest ADHD Treatment Center
Patient Referral Form

Referring Provider's Name:_____ Organization:_____

Phone Number: _____ Ext:_____

Fax Number: _____

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):

- ❏ Corvallis: *883 NW Grant Ave, Corvallis, OR, 97330*
- ❏ East Portland: *13908 SE Stark, Suite A, Portland, OR 97233*
- ❏ 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

_____

_____

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 (971) 223-0985. For questions regarding referrals please reach out to our Intake Coordinator by phone at (503) 427-2394 (press 6).