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:_____

Pronouns & Preferred name : _____ Legal sex:_____

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*
- ❏ Downtown Portland: *1800 SW 1st Ave., Suite 400, Portland, OR 97201*
- ❏ East Portland: *560 SE 139th Ave., Portland, OR 97233*
- ❏ West Portland: *12570 SW 69th Ave., Suite 200, Portland, OR 97223*
- ❏ Virtual / Remote

Which new patient service (s) are you referring this patient for:

- ❏ *ADHD evaluation only*
- ❏ *ADHD evaluation and treatment if applicable*
- ❏ *Group therapy*

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 further information regarding this patient on the back of this form. At minimum, sending the most recent chart note is required. Send 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.