A New Hampshire Limited Liability Company

111 Riverway PL
Bedford. NH 03110

Tel. (603) 622-1112
Fax. (888) 965-6870

Referral Date: _______________

Referring Provider: ______________________________________ NPI #:____

Practice Name: ____ Phone: ____

Practice Address: ____ Fax. ____

Patient's Name: ____ DOB: ________________ Phone: ________________________

Health Insurance: ______________________________ ID#: _________________________________ Group #: ______________________

Subscriber's Name: ____ Subscriber's DOB: ________________________________

Referral for Outpatient Appointment

Thank you for this referral. Please complete the information below so we may process your request quickly. We will contact your patient prior to scheduling, and we will notify your office when the visit is scheduled.

Referred For:

- Consultation & Assessment ❑
- Assess & Treat ❑
- Second Opinion ❑

Comments:

Primary Diagnosis/Presenting Symptoms:

ICD-10 Dx Code(s): ________________ ________________ ________________ ________________

Known Contraindications:

Case history sent: ❑ w/patient ❑ separate cover ❑ Fax

Optional:

Visits / Week / # Weeks: ___________________________ Session Length: ❑ 15 ❑ 30 ❑ 60 minutes