PINNACLECARE
ACHIEVING HEALTHIER OUTCOMES

DATE:

BEHAVIORAL HEALTH REFERRAL

SERVICES:
Check All that Apply

- ☐ Medication Management
- ☐ Counseling
- ☐ Behavioral Health Testing
- ☐ Autism Play Therapy
- ☐ EMDR
- ☐ iLS
- ☐ Substance Abuse
- ☐ Case Management
- ☐ Parent-Child Interaction (PCIT)

PATIENT INFORMATION

Name:_____ DOB:_____

SSN:_____ Medicare:_____

Medicaid:_____ Insurance:_____

PROVIDER INFORMATION

Referring Provider (*Please Print*):_____

☐ I authorize Pinnacle Care to evaluate the patient listed above and provide any behavioral health services.

Provider Signature:_____ Date:_____

**Provider signature only required for Medicare patients*

☐ I agree that my electronic signature above is the legally binding equivalent to my handwritten signature.

PLEASE SEND

Please Send Referral & Documents to
FAX: 877-725-8976 **CALL:** 580-740-4053 or
EMAIL: info@pinnaclecareok.com

- ✓ Face Sheet/Demographics
- ✓ Medication List
- ✓ Any Additional Documents Needed