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

## PATIENT INFORMATION

Name:_____ DOB:_____

Phone:_____ 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 Att: Brandi

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