

Serene Waters Mental Health Referral Form

Date: _____

Referring Provider: _____

Referring Provider Phone: _____ Fax: _____

Referring Provider NPI: _____

Referring Provider Address: _____

Patient Name: _____ Age: _____ DOB: _____

Phone: Home _____ Cell _____

Address: _____

Insurance Company: _____

Insurance Policy #: _____ Group #: _____

Services requested: ____ Medication Management ____ Counseling

DX Codes/description: _____

Detailed reason for referral:

Referring Provider Signature

Please Fax the completed form to (907-) 435-3053.