AvanceCare®

Specialty Services Referral Form

Behavioral Health • Nutrition • Psychiatry

Please Fax or Email the completed referral form.
Our team will reach out to the patient.
Fax: 984.263.4431
Email: specialtyreferrals@avancecare.com

Date of Referral: _____

☐ Urgent ☐ Standard

1. Patient Information

Patient Name: _____ **Date of Birth:** _____/_____/_____

Phone Number: (_____) _____-_____

Insurance (Primary):_____ **Member ID/Group #:** _____

2. Referring Provider Information

Referring Provider Name

_____

Organization

_____

Phone

_____

Email/Preferred Contact

_____

3. Care & Services Needed

Diagnosis/Reason for Referral _____

Check all that apply:

- ☐ General Psychiatry
- ☐ Addiction Care Psychiatry
- ☐ Aging/Geriatric Care Psychiatry
- ☐ Child & Adolescents Psychiatry
- ☐ Pain Management
- ☐ Treatment-Resistant Depression *(TMS/Spravato/VNS)*
- ☐ Behavioral Health Therapy
- ☐ Nutrition Services

Assessments:

- ☐ ADHD Assessment
- ☐ Autism Assessment
- ☐ Cognitive Diagnostic Assessment *(to support referring provider to diagnose or treat)*

Therapy Groups

- ☐ ADHD
- ☐ Addiction Discovery
- ☐ Addiction Action
- ☐ Chronic Pain
- ☐ DBT- Informed
- ☐ Disordered Eating

4. Provider Preference

Location _____

Specialization in Care _____

Therapist Preferences
(We will do our best to accommodate.)

Gender _____

Language _____

Notes:

HIPAA and 42 CFR Part 2 Disclosure Notice: If this referral includes any information that identifies the patient as having a substance use disorder (SUD), receiving SUD treatment, or being referred for SUD-related services, the referring provider is responsible for ensuring that the disclosure complies with all applicable privacy laws, including HIPAA and 42 CFR Part 2. This includes obtaining any required patient authorization prior to sending protected information. By submitting this referral, the referring provider attests that any SUD-related information has been disclosed in accordance with these requirements.