PATIENT REFERRAL FORM

Adult Intensive Outpatient Program (IOP) · TJC-Accredited
6404 International Parkway, Suite 1010, Plano, TX 75093

RETURN COMPLETED FORM — Fax: _____ Email: admin@ascenthealthcaretx.com Phone: 214-249-9201

Referral urgency: ☐ Routine ☐ Urgent *Same-day / next-business-day intake available · Referral response within 4 business hours*

PATIENT INFORMATION

PATIENT FULL NAME

DATE OF BIRTH

PHONE

EMAIL

PREFERRED CONTACT METHOD / BEST TIME

ADDRESS (STREET, CITY, STATE, ZIP)

PERMISSIONS

☐ OK to leave voicemail

☐ Patient is aware of this referral

INSURANCE INFORMATION

INSURANCE CARRIER / PLAN

MEMBER ID

GROUP #

SUBSCRIBER NAME (IF NOT PATIENT)

SUBSCRIBER DOB

INSURANCE PHONE (BACK OF CARD)

REASON FOR REFERRAL

PRIMARY DIAGNOSIS / PRESENTING CONCERNS

CURRENT MEDICATIONS (IF KNOWN)

ADDITIONAL CLINICAL NOTES — RECENT HOSPITALIZATION, SAFETY CONCERNS, TREATMENT HISTORY, GOALS FOR IOP

REFERRING PROVIDER / PRACTICE

PROVIDER NAME & CREDENTIALS

PRACTICE / ORGANIZATION

CONTACT PERSON FOR THIS REFERRAL

PHONE

FAX

EMAIL

DATE OF REFERRAL

COMPLETED BY (NAME & ROLE)

ASCENT BD REPRESENTATIVE (IF ASSISTED)

What happens next: Our team responds to every referral within 4 business hours. Intake is typically scheduled same-day or next business day, and we provide outcomes communication back to your office from admission through discharge.

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