Williamsville Wellness

PATIENT REFERRAL FORM

Referring Provider/Org _____ Patient Name _____

Contact Name _____ Date of Birth _____

Phone _____ Patient's Phone Number _____

**Please answer the questions below.

How did you learn about us? _____

Does the patient have insurance? ☐ Yes ☐ No If yes, which one _____

If yes, what is their policy number? _____

**Please mark all reasons the patient is seeking treatment

- ☐ Substances
- ☐ Alcohol
- ☐ Gambling
- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ OCD
- ☐ Other

_____

**Please verify patient consent

I attest that I have obtained appropriate consent from the patient (or their legal guardian) to share their clinical information with Williamsville Wellness for the purpose of treatment evaluation and admission.

☐ Yes, I obtained consent from the patient

Referrer Signature _____ Date _____

Once finished, save this form and email it to information@williamsvillewellness.com