

EMPOWERMENT MENTAL HEALTH LLC

4300 B Street, Suite 410
Anchorage, AK 99503
Office: (907) 231-2333 / Fax: (907) 222-6153

Referral Form

Please fill out the below form and fax to 907-222-6153 to initiate your referral for screening for appropriateness.

Date of Referral: _____

Referring Provider: _____

Facility: _____

Phone: _____ Fax: _____

PATIENT DEMOGRAPHIC INFORMATION

Patient's name: _____ Birth date: _____

Home address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Primary Insurance: _____ ID/Policy Number: _____

Subscriber name: _____

Secondary Insurance: _____ ID/Policy Number: _____

Subscriber name: _____

CLINICAL INFORMATION

Reason for Referral:

Current Psychiatric Diagnoses (please include provisional and/or rule outs):

Current Psychiatric Medications (name & dose, attach list if preferred):

Signature of Referral Source: _____ Date: _____

Send completed referral form to Empowerment Mental Health LLC. Please include any relevant materials, releases of information, or other supporting documentation (such as previous mental health and psychiatric assessments, psychological testing reports, relevant medical reports, progress notes, labs etc.) Please fax this completed form and attachments to: 907-222-6153. Thank you!