ALLEVIANT
HEALTH CENTERS™

(866) 951-HEAL *phone* ◆ (501) 708-2185 *fax* ◆ newpatients@allevianthealthcenters.com

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Referral Form

At Alleviant Health Centers we seek to collaborate with referring providers to optimize patient care and provide adjunct therapy as needed. By signing below you are acknowledging that you are willing to engage with Alleviant Health Centers staff / physicians in a consulting / collaborative capacity for the betterment of your patient's condition so long as they are actively seeking services from Alleviant Health Centers. Your patient's continuity of care is of the utmost important to us. Please provide the following:

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

Patient Phone Number: _____ **Diagnosis:** _____

Provider Name: _____ **Speciality:**_____

NPI Number: _____ **Email:**_____

Address: _____

Phone: _____ **Fax:** _____

How did you hear about us? _____

Please 1) circle the appropriate clinic location and 2) check the recommended service(s) for this patient:

Little Rock, AR	**Honolulu, HI**	**Naples, FL**
☐ Infusion Services	☐ Infusion Services	☐ Infusion Services
☐ TMS Therapy	☐ TMS Therapy	☐ TMS Therapy
☐ Medication Management	☐ Medication Management	
☐ Psychotherapy		
☐ Other: _____	☐ Other: _____	☐ Other: _____

Provider Signature: _____ **Date:** _____

Please fax this form with your most recent evaluation of the patient to (501) 708-2185.