

Optima Behavioral Health, Inc.

81 Outerbelt Street | Columbus, OH 43213

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www.optimabh.com

REFERRAL FORM

INCOMPLETE, INACCURATE, OR ILLEGIBLE INFORMATION MAY RESULT IN A DELAY OR REJECTION OF REFERRAL. PLEASE ALLOW 7-10 (BUSINESS) DAYS FOR OUR OFFICE TO CONTACT YOU OR YOUR PATIENT.

PATIENT INFORMATION	
Patient Name:	
DOB:	/ /
Phone #:	()
Insurance Information:	PLEASE FAX A COPY OF THE INSURANCE CARD AND A COPY OF THE FACESHEET
Previous Hospitalizations:	PLEASE FAX ALL PREVIOUS HOSPITAL RECORDS REQUIRED BEFORE SCHEDULING N/A <input type="checkbox"/>
Previous Medications:	PLEASE LIST ALL PREVIOUS & CURRENT MEDICATIONS FOR THE LAST ROLLING CALENDAR YEAR N/A <input type="checkbox"/>

REFERRAL INFORMATION	
Referring Provider:	
Contact #:	Phone: () Fax: ()
Comments:	INCLUDE CLINICAL REASON FOR SCHEDULING + INCLUDE THE LAST 3 PROGRESS NOTES

NOTICE: We are NOT accepting:

- Any court probations or orders
- Substance Abuse
- Disability (SSA/D, FMLA, STD/LTD, LOA, etc.)

PLEASE SPECIFY WHICH PROVIDER YOU PREFER YOUR PATIENT TO BE SCHEDULED WITH

PSYCHIATRIST: NO | YES – if yes:

STEVEN SCHNEIR, MD	CONNIE HIRSH, MD	HOLLY SCHWEITZER, CNP	MICHAEL TICHY, CNP	MELANIE LINT, CNS	ANYONE ON PLAN
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THERAPIST: NO | YES – if yes:

D. SCHNEIR	L. BAKER	G. BYERS	D. SHERMAN	K. FULLER	V. SPOHN	D. CONN	R. GAINES	ANYONE ON PLAN
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