MidValley Healthcare

Referral Form

From: Provider: _____

Ph: _____ **Fax:** _____

Pt Name: _____ **Ph**: _____

DOB: _____ (Must be 18 years or older)

Reason for referral: ____Medication Management
____Transcranial Magnetic Therapy (TMS) ____Counseling

_____

_____

_____

_____

Please attach the following:
____Evaluation (within last 6 months)
____Last progress note
____Medication list
____Face Sheet (Name, address, phone number, and insurance name with Policy number)
____D/C instructions and notes (*referral from hospital only*)

Please fax referral and documents to: (208) 888-0884

MidValley will call the patient to set all appointments
Any questions, please call: (208) 888-5848

Thank you for your referral

Office use only: Received by: _____
Appts: LCSW:_____ Medical:_____

*2321 E Gala Street, Ste 3, Meridian, ID 83642 * Main Phn: (208) 888-5848 * Fax: (208) 888-0884*
303 N Allumbaugh St., Ste 335, Boise, ID 83704