GrowWell

Behavioral Health
by BROWN BEHAVIORAL HEALTH SERVICES

Telehealth Referral Form

Referring Clinic/Source _____

Phone: _____ Fax: _____

Diagnosis: _____ ICD10 Code: _____

Referring Provider: _____ Signature: _____

Patient Information

Name: _____ Date of Birth: ___/___/___ Male ☐ Female ☐
FIRST MI LAST

Race: ◯ American Indian ◯ Asian ◯ Black ◯ White ◯ Pacific Islander **Ethnicity:** ◯ Hispanic or Latino ◯ Non-Hispanic or Latino ◯ No data available

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Pref. Language: _____

Insurance Provider: _____ **ID#:** _____

Who should Brown Behavioral send notes to?:

Secure Fax: _____ Secure Email: _____

PLEASE FAX FORM TO BROWN BEHAVIORAL HEALTH:
(901) 425-9773
PHONE: (901) 228-9068