MidValley Healthcare
2321 E Gala St Ste 3
Meridian, ID 83642
(208) 888-5848
www.midvalleyhealthcare.com

Referral Form

From: Provider: _____
Ph: _____
Fax: _____

Pt Name: _____ Ph: _____
DOB: _____ (Must be 18 yoa or older)

Reason for referral: ____IOP (9 hrs/ wk) ____Psychiatric ____Chemical Dependency ___Counseling
_____
_____
_____
_____
_____

Urgency of Appointment:
_____First available appointment
_____Urgent

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)

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, Date, and time:_____
PA, NP, MD, Date, and time:_____