



**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: \_\_\_\_\_

The information contained in this transmission is privileged and confidential information intended only for use of the individual or entity named above. If you receive this communication in error, please call (208) 888-5848 IMMEDIATELY and destroy this fax. Thank you