Canyon Health Centers Referral Form

Client Information

Full Name: _____

Date of Birth: _____ Gender: _____

Address: _____

Phone Number: _____ Alternate Phone: _____

Email Address: _____

Preferred Language: _____

Insurance Information

Insurance Provider: _____

Policy/Member Number: _____

Group Number (if applicable): _____

Primary Policyholder (if different): _____

Reason for Referral

Primary Diagnosis (if known): _____

Secondary Diagnosis (if applicable): _____

Symptoms/Concerns: _____

Specific Services Requested (check all that apply):

- ○ Partial Hospitalization Program (PHP)
- ○ Intensive Outpatient Program (IOP)
- ○ General Outpatient Services (therapy, case management, psychiatric care)
- ○ Other: _____

Referring Provider Information

Referring Doctor/Provider Name: _____

Practice/Organization Name: _____

Phone Number: _____ Fax: _____

Email: _____

Provider NPI Number: _____

Clinical Information

Assessment Conducted? (circle one): Yes / No

Date of Last Assessment: _____

Relevant History or Notes:

Attachments
Please include the following, if available:

- Most recent clinical notes or summary.
- Diagnostic testing results.
- Insurance verification or authorization forms.
- Other relevant medical or mental health documents.

Authorization
By signing below, I authorize the release of the above client information to Canyon Health Centers for the purpose of coordinating behavioral health services.

Referring Provider Signature: _____

Date: _____

How to Submit

Please return the completed form via:

- **Email**: info@canyonhealthcenters.com
- **Fax**: 480-903-7171

Mail:
Canyon Health Centers LLC
7000 N. 16th St
Suite 120-168
Phoenix AZ 85020-5547

For questions or follow-up, contact us at 480-903-6463.