

Bold Behavioral Health, PLLC

Telehealth psychiatric evaluation and medication management for adults in Iowa

Phone: 515-207-9693

Fax: 515-512-1502

PROVIDER REFERRAL FORM

Complete this form and fax it to the number above, or call 515-207-9693. We see adults (18+) who are physically located in Iowa. This form is not for emergencies: if a patient is in crisis, call or text 988 or call 911.

1. REFERRING PROVIDER

Provider name / credentials: _____ Practice / organization: _____

Phone: _____ Fax: _____ Date: _____

2. PATIENT

Patient name: _____ Date of birth: _____ Phone: _____

Best times to reach: _____ OK to leave a voicemail? ☐ Yes ☐ No

Insurance: ☐ Wellmark / BCBS ☐ Other plan: _____ ☐ Self-pay ☐ Unknown

Member ID (if known): _____

3. REASON FOR REFERRAL

☐ ADHD evaluation ☐ Depression ☐ Anxiety ☐ Bipolar disorder

☐ Medication management / transfer of care ☐ Other: _____

Brief reason for referral and relevant history:

Timing: ☐ Routine ☐ Time-sensitive (please explain above)

4. CLINICAL INFORMATION

Current psychiatric medications (name and dose) and prior treatment:

Current safety concerns (suicidal or homicidal thoughts, recent hospitalization)? ☐ No ☐ Yes

If yes, describe: _____

Patient currently sees a therapist? ☐ Yes ☐ No Therapist name / phone: _____

5. CONSENT AND RECORDS

☐ The patient knows about this referral and agrees to be contacted by Bold Behavioral Health.

☐ Records attached ☐ Records to follow ☐ Patient authorization to release records is on file

Referring provider signature: _____ Date: _____

CONFIDENTIALITY NOTICE: This fax contains protected health information that is confidential under federal and state law. It is intended only for Bold Behavioral Health, PLLC. If you received it in error, please call 515-207-9693 right away and destroy all copies. Any unauthorized review, use, or disclosure is prohibited.