THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

HTP Referral Form

The Healthy Teen Project looks forward to partnering with you in your patient's care.

Date: _____ ☐ Routine ☐ Urgent

REFERRING PROVIDER INFORMATION:

Referred by: _____

Phone: _____ Fax: _____ PCP: _____

Address: _____ City: _____ ZIP: _____

This form completed by: _____ Phone: _____

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PATIENT INFORMATION (Please provide copy of patient demographics/face sheet):

Last Name: _____ First Name: _____MI: _____

DOB: _____ Phone: _____

Gender: ☐ Male ☐ Female

Parent's Name: _____ Phone: _____

Patient's Address:_____

City/State/Zip: _____

Needs interpreter? ☐Yes ☐ No Language: _____

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REASON FOR REFERRAL:

Reason for Referral: _____

_____

_____

_____

DOCUMENTATION REQUIRED (Please fax with this form): ☐ Recent/relevant typed clinical notes/test results, i.e. history & physical, etc. ☐ Proof of insurance ☐ Authorization information (if required)

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