FAX REFERRAL to 480-750-0097
Or
referrals@aliumhealth.com
www.aliumhealth.com

Date: ________________

Patient Referral Form

Patient Information

Name:	DOB:	Email:
Phone:	Insurance:	
ID #:	Group #:	
Priority Level: ☐ Standard (up to 48 hrs) ☐ Priority (up to 24 hrs) ☐ Stat (same day)		

Referral From

Referring Physician Name:	Email:
Practice Name:	
Location:	
Phone:	Fax:

Referral To Alium Health

Service Requested (circle):	**Behavioral Health / PCP / Nutrition / Sub Abuse / Psych Med Mgt** **TMS / Spravato / Diabetes / Other (fill in):**
Locations: Scottsdale or Mesa or Telehealth	

Referral Information

Reason for Referral:
Notes:

PRINT NAME of person completing form______________________________ Date: ______________________

WE KINDLY REQUEST THAT YOU SEND ALL PERTINENT MEDICAL RECORDS

Fax Referral to 480-750-0097 or Email referrals@aliumhealth.com

Thank you for your Referral. We greatly appreciate it

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