Tapestry

Premier Program by Pyramid Healthcare

Fax Referral Form

Provider Info

Practice Name: _____ Physician:_____
Phone: _____ Fax: _____
Address: _____
Contact: _____ Phone: _____

Patient Information

Name: _____ DOB:_____ Age:___ Gender: ____
Address: _____
City: _____ State: _____ Zip: _____
School that Patient Attends: _____

Guardian: _____ Phone: _____
Email: _____ Best Time to Contact: _____
Preferred Method of Contact: ___ Phone ____ Email

Dx: _____ ICD-10 code:_____
Height: _____ Weight: _____ BMI: _____

Reason for Referral/ behaviors: _____
_____
_____

Recommended Level of Care: ____ Partial Hospitalization Program (M-F 6hrs/ day)
____ Intensive Outpatient Program (3x/ wk, 3hrs/ day)
____ Outpatient Program
____ Based on clinical staff evaluation

Insurance Information

Insurance Company: _____ ID#:_____
Subscriber Name: _____ SSN: _____
DOB: _____ Relationship: _____
Mental Health Customer Service phone: _____
(please attach copy of front and back of card)

********Fax to: (888) 218-9797********

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119 Tunnel Rd Suite B Asheville NC 28805
phone: (828) 884-2475 email:intake@TapestryNC.com