

ForwardCare

Patient referral form

Fax to (972) 945-2112 · or email referrals@forwardcare.com (encrypted) · Questions: (832) 681-9643

Fill in, then fax or email. Our intake team calls the patient within one business day.

1 About you (referrer)

First name *

Last name *

Organization / practice *

Your role

Work email * (receipt and updates go here)

Work phone *

Your state *

☐ I have referred to ForwardCare before

2 About the patient

Patient first name *

Patient last name *

Date of birth * (MM / DD / YYYY)

City

ZIP code *

Whose contact information is this? *

☐ Patient ☐ Guardian

Guardian name (if guardian)

Relationship to patient

Contact phone *

Contact email

Who should ForwardCare reach out to? *

☐ Patient / guardian ☐ Referrer (myself) ☐ Both

What does your patient need support with? * (select all that apply)

☐ Mental health ☐ Substance use ☐ Eating disorder

Reason for referral * (presenting concerns, level of care needed, anything intake should know before calling)

ForwardCare

Patient referral form (continued)

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3 Insurance

What type of insurance does the patient have? *

☐ Commercial / Private ☐ Medicaid ☐ Other ☐ I don't know

Insurance carrier (tick one)

☐ Aetna	☐ Anthem	☐ Blue Cross Blue Shield
☐ Cigna	☐ Humana	☐ Magellan
☐ Tricare	☐ Triwest	☐ UnitedHealthcare
☐ Other		

Member ID

☐ Insurance card copy attached (front and back)

☐ Supporting documents attached (e.g. clinical charts)

Any other thoughts, questions or feedback for the ForwardCare team?

4 Consent

☐ The patient (or their guardian) knows I am making this referral and agrees to be contacted by ForwardCare. *

☐ Send me intake and discharge updates for this patient (with patient consent).

Referrer signature

Date
