REFERRAL FORM

1525 River Oaks Road West
New Orleans, LA 70123

Admissions Department
Phone: 1-800-366-1740
Email: riveroaksadmissionsfax@uhsinc.com
Fax: 504-733-3229

Date: _____

TREATMENT PROGRAM REQUESTED:

- ☐ **Adolescent Program (12 – 17 yrs.)**
- ☐ **Adult Psychiatric Program (18 yrs. and older)**
- ☐ **Dual Diagnosis Program (18 yrs. and older)**
- ☐ **Intensive Outpatient or Partial Hospitalization Program (18 yrs. and older)**

Referral Forms for our trauma and eating disorders programs can be found at www.riveroakshospital.com/admissions

PATIENT NAME: _____ Age: _____ DOB: _____

Presenting Problem: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ SSN: _____ Insurance Co: _____

Insurance Policy Number: _____

Is the patient voluntary? ☐ **Yes** ☐ **No**

If no, please submit appropriate documentation. This information is required before MD orders can be given.

***Completed Certificate of Need is required for Medicaid recipients ages 6 – 20 years old.**

REFERRING PHYSICIAN/CLINICIAN: _____

Phone: _____ Fax: _____ E-mail: _____

Facility: _____

Address: _____ City: _____ State: _____ Zip: _____

Return this form via Fax: **504-733-3229** or email: **riveroaksadmissionsfax@uhsinc.com**

Insurance Plans Accepted (not limited to this list):

Medicare, Tricare, BCBS, Cigna, United, Magellan, Humana, Gilsbar, Aetna, Beacon Health Options, MHN, VA, Wellcare,

A member of our admissions department will follow up with you regarding program availability.