Patient Referral Request

Requesting Physician/Health Care Professional Information: PLEASE PRINT CLEARLY

Date of Request	
Provider Name	**FIRST NAME:** **LAST NAME:**
Name of Company	
Phone Number	( ) -
Fax Number	( ) -
Name of Person Completing Form	

Patient Information: PLEASE PRINT CLEARLY

Patient Name	**FIRST NAME:** **LAST NAME:**	
Date of Birth	/ /	☐ Male ☐ Female
Phone Number	( ) -	Alt. Number ( ) -
Street Address		
City & State, Zip		
Primary Insurance		Network:
Insurance Policy #		Group #:
Policy Holder Name	**FIRST NAME:** **LAST NAME:**	
Date of Birth	/ /	**Relationship to Patient**: SELF SPOUSE MOTHER FATHER OTHER
Secondary Insurance		Network:
Insurance Policy #		Group #:
Policy Holder Name	**FIRST NAME:** **LAST NAME:**	
Date of Birth	/ /	**Relationship to Patient**: SELF SPOUSE MOTHER FATHER OTHER
Reason for Appt.		

Check type of appointment needed below. Please include chart notes and insurance card.

☐ *Urgent:* See tomorrow or next business day ☐ *Routine:* See within 7-14 business days

Please fax to the referring **American Behavioral Clinic location** and call to schedule appointment.
For additional forms to download and print go **Online** to
www.AmericanBehavioralClinics.com

Bluemound Clinic
10424 W. Bluemound Rd
Milwaukee, WI 53226
Phone: (414) 774-1794
Fax: (414) 774-1488

Elm Grove Clinic
15285 Watertown Plank Rd
Elm Grove, WI 53122
Phone: (262) 797-2818
Fax: (262-797-2814

Layton Clinic
7330 W. Layton Ave
Milwaukee, WI 53220
Phone: (414)281-1677
Fax: (414) 281-0884

Mequon Clinic
1240 W. Ranchito Lane
Mequon, WI 53092
Phone: (262) 241-3231
Fax: (262-241-4311