Patient Referral

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:** **M.I.:** **LAST NAME:**	
Date of Birth		☐ Male ☐ Female
Phone Number	( ) -	Alt. Number ( ) -
Street Address		
City & State, Zip		
Insurance Name		
Insurance Policy #		
Reason for Appt.		

Please check how patient referral will establish care at American Behavioral Clinics.

☐ *Verbal Consult* Patient is in the referring office at time of scheduling. ABC completes form over the phone.
Person calling: _____

☐ *Patient Will Call* Patient will call American Behavioral Clinics to schedule appointment. Please have insurance card information available.

Please fax to the referring **American Behavioral Clinic location**.
If the patient is in your office and you need immediate service, please call the preferred clinic.

For additional forms to download and print go **Online** to
www.AmericanBehavioralClinics.com

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

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

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

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