South Community
Positive Health Options

3095 Kettering Blvd
Dayton, Ohio 45439

PHYSICIAN REFERRAL FOR MEDICATION MANAGEMENT SERVICES

FAX COMPLETED FORM TO 937-534-1351

PATIENT INFORMATION

First Name: _____ Last Name: _____ DOB: _____

Address: _____Phone Number: _____

Town/City: _____State: _____ Zip Code: _____ Email: _____

*Can a voicemail be left at this number for an appt? ____Y ____ N

Primary Insurance: _____ Policy #:_____Group #:_____

Policy Holder Name: _____Card/Bin # _____

Caregiver's Name:_____Caregiver's Phone Number: _____

REFERRING PHYSICIAN INFORMATION

***We do not accept referrals for management of Benzodiazepines or Sleep Aids.**

Referring Provider Name: _____ Address: _____

Town/City: _____State: _____ Zip Code: _____ Email: _____

Phone Number: _____ Fax Number: _____

Type of Services Needed: _____ Adult ____Child

MEDICAL HISTORY

Current Diagnosis:

_____

_____

Current Treatment:

_____

_____

Current Medications:

_____

_____

SCHEDULING NOTES (Office Use Only)

Appt. Scheduled for the following:

Date: _____ Spoke with:_____

Time: _____ ____ Mother _____ Father ____ Guardian

Provider Scheduled with: _____

***MUST INCLUDE RELEASE OF INFORMATION (ROI) FOR REFERRING PHYSICIAN**