SPRINGWOODS
BEHAVIORAL HEALTH

REFERRAL FORM-Assessment and Admissions Department

1955 West Truckers Drive Fayetteville Arkansas 72704

479-973-6000 office, 479-571-5390 fax

Date: _____

Treatment Program Requested: (circle one)

- **Inpatient Programs:**
  - Adolescent Psychiatric Program (12-17)
  - Girls Only Adolescent Psychiatric Program (12- 17)
  - Adult Psychiatric Program(18 & older)
  - Center for Women Program (18 & older)

- **Outpatient Adult Programs:**
  - Adult Partial Hospital Program (M-F) 9:00 A.M – 2:30 P.M.
  - Adult Intensive Outpatient Program (M-TH) 9:00 A.M.- 12:00 P.M.
  - Changing Paths is an outpatient medication assisted treatment for individuals with opiate dependence.
  - Medication Management
  - Adolescent Partial Hospital Program (M-F) 4:00 P.M. – 8:30 P.M.

Presenting Problem: _____

_____

Patient Name: _____Age_____ DOB_____

Address: _____ City: _____State: _____ Zip_____

Phone: _____ SSN: _____ Insurance: _____

Insurance Policy Number: _____

Referring Physician/ Clinician: _____

Phone: _____ Fax: _____ Email: _____

Facility/Practice Name: _____

Address: _____ City: _____State: _____ Zip_____

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