



REFERRAL FORM-Assessment and Admissions Department

1955 West Truckers Drive Fayetteville Arkansas 72704

Phone 479-973-6000 Option 1, Fax 479-571-5390 or

Email springwoodsinc@uhsinc.com

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

Presenting Problem: _____

Patient Name: _____ Age _____ DOB _____

Guardian _____

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.