F A X **Fortis Behavioral Health Referral**	To: DEANA FLYNN, PMHNP-BC Phone: 910-536-1719 Fax: 910-668-8048
	From: Phone: Fax:
	Date:
	Regarding: Patient referral

PATIENT NAME:________________________________DOB:_____________

PATIENT TELEPHONE:____

PURPOSE OF REFERRAL:____

Insurance:____

Diagnosis/Problem:____

We do not see patients under the age of 6

We do evaluate for ADHD (ages 6 through adulthood) and Autism (Ages 6-17)

Please note we do not take patients with a high acuity level to include: schizophrenia, addiction, or patients with past or current self-harm, suicidal ideation or suicide attempts.