WELLNESS SERVICES REFERRAL FORM

Inspired Now Wellness and Community Partners, LLC

Thank you for referring your patient to our wellness services. This form helps us coordinate care and provide appropriate support.

PATIENT INFORMATION

Date of birth:*

Patient Name:*

First Name:

Last Name:

Gender:*

- Female
- Male
- Female-to-Male (FTM)/Transgender Male/Trans Man
- Male-to-Female (MTF)/Transgender Female/Trans Woman
- Genderqueer, neither exclusively male nor female
- Other
- Choose not to disclose

Phone Number:*

Email Address:*

Address:*

Line 1:

City:

Line 1:

Country:

State:

Zip Code:

INSURANCE INFORMATION (If Applicable)

Primary Insurance:

Policy/Member ID:

Medicaid or Managed Care Plan:

SERVICES REQUESTED

(Check all that apply):*

Please select all that apply

- ☐ Individual Health & Wellness Coaching
- ☐ Group Wellness Programs
- ☐ Stress Management & Burnout Support
- ☐ Chronic Condition Self-Management Support
- ☐ Preventive Lifestyle Education
- ☐ Women's Holistic Wellness Services
- ☐ Care Coordination Assistance
- ☐ Corporate/Workplace Wellness (if applicable)
- ☐ Other

REFERRAL REASON & CLINICAL NOTES (Optional)

Please provide any relevant clinical information that would help us support this patient's wellness goals:

Primary diagnosis/condition (if relevant):

Wellness goals or areas of focus:

Current medications or treatments (if relevant to wellness services):

Specific concerns or contraindications:

COMMUNICATION PREFERENCES

(Check all that apply)*

Please select all that apply

- ☐ Please send progress updates to my office
- ☐ No communication needed - patient will follow up independently
- ☐ Please contact me if patient does not engage within 30 days

REFERRING PROVIDER INFORMATION

Referring provider*

Credentials:

Please select one

○ MD ○ DO ○ NP ○ PA ○ Other

Practice/Organization: *

Office Address: *

Line 1:

City:

Line 1:

Country:

State:

Zip Code:

Office Phone: *

Office Fax:

Provider Email: *

NPI Number (if billing involved):

AUTHORIZATION & SIGNATURE

I authorize Inspired Now Wellness to contact and provide wellness services to the above-named patient*

Please select one

- Yes

I understand that wellness services are non-clinical and do not replace medical treatment*

Please select one

- Yes

I authorize Inspired Now Wellness to communicate with my office regarding this patient's participation and progress (if requested above)*

Please select one

- Yes

Referring Provider Signature:*

(This will require your client's signature)

Date:*