

Printable Fax Referral Form

Send fax to **Boise ADHD** at fax number **208-443-5413**.

☐ Request for confirmation of fax via fax from Boise ADHD (check this)

Referring Provider: _____

Referring Clinic/Agency: _____

Referring Provider Phone contact: _____

Patient/Client Name: _____

Patient/Client Age and Birthdate: _____

If minor, parent names: _____

Client telephone contact: _____

Referral questions to be answered (please check all that apply):

- ☐ ADHD
- ☐ Anxiety
- ☐ Depression
- ☐ Learning Disability
- ☐ Oppositional Defiant Disorder
- ☐ High Intelligence
- ☐ Autism Spectrum Disorder
- ☐ Psychotic symptoms
- ☐ Sensory Issues
- ☐ Trauma
- ☐ Dissociation
- ☐ Obsessive Compulsive Disorder
- ☐ Danger to self and/or others
- ☐ Other: _____

