***Horizon Ridge Clinic** abides by all HIPAA regulations and requirements. All information shared will remain confidential and will only be used to provide the best care possible for your client.*

Client Name: ____ Date of Birth: _________

Client Address: ____

Telephone/Contact Number: ___________________________ Medicaid Recipient ID: ____________

Parent/Guardian Name(s): ____

Referring Office: ____

Whom may we thank for this referral? ____

*Thank you for referring **Horizon Ridge Clinic** for your client's needs. **Horizon Ridge Clinic** operates in accordance with medical policies and statutes. With specialized care, strict medical supervision, and clinical oversight, your client will receive an immediate phone call. We'll conduct an assessment, determine medical necessity, and identify service needs. As a referring professional, we'll contact you to schedule a start date with your client.*

SYMPTOMS AND/OR SIGNIFICANT LIFE EVENTS:
Please list symptoms and/or significant life events that relate to the client's diagnosis (pertinent family history, developmental history, medical issues, history of abuse, neglect, etc.)

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Contact us today!

Referral:

(702) 221-1317 (Voice Mail)

(702) 489-8264 (Fax)

contact_us@horizonridgeclinic.com