HICKORY TRAIL
HOSPITAL
BEHAVIORAL HEALTH SERVICES

REFERRAL FORM

Admissions Department
2000 Old Hickory Trail, Desoto, TX 75116
Phone: (971) 298-7323
Fax: (214) 389-7444

Date: _____

TREATMENT PROGRAM REQUESTED:

- ☐ **Children Psychiatric Program (5 -11 yrs.)**
- ☐ **Adolescent Psychiatric Program (12 – 17 yrs.)**
- ☐ **Adult Psychiatric Program (18 yrs. and older)**
- ☐ **Dual Diagnosis Program (18 yrs. and older)**
- ☐ **Intensive Outpatient or Partial Hospitalization Program (12 yrs. and older)**

PATIENT NAME: _____ Age: _____ DOB: _____

Presenting Problem: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ SSN: _____ Insurance Co: _____

Insurance Policy Number: _____

REFERRING PHYSICIAN/CLINICIAN: _____

Phone: _____ Fax: _____ E-mail: _____

Facility: _____

Address: _____ City: _____ State: _____ Zip: _____

A member of our admissions department will follow up with you regarding program availability.