



Tapestry

Premier Program by Pyramid Healthcare

Fax Referral Form

Provider Info

Practice Name: _____ Physician: _____
Phone: _____ Fax: _____
Address: _____
Contact: _____ Phone: _____

Patient Information

Name: _____ DOB: _____ Age: _____ Gender: _____
Address: _____
City: _____ State: _____ Zip: _____
School that Patient Attends: _____

Guardian: _____ Phone: _____
Email: _____ Best Time to Contact: _____
Preferred Method of Contact: Phone Email

Dx: _____ ICD-10 code: _____
Height: _____ Weight: _____ BMI: _____

Reason for Referral/ behaviors: _____

Recommended Level of Care: Partial Hospitalization Program (M-F 6hrs/ day)
 Intensive Outpatient Program (3x/ wk, 3hrs/ day)
 Outpatient Program
 Based on clinical staff evaluation

Insurance Information

Insurance Company: _____ ID#: _____
Subscriber Name: _____ SSN: _____
DOB: _____ Relationship: _____
Mental Health Customer Service phone: _____
(please attach copy of front and back of card)

*******Fax to: (828) 654-0920*******

11 N Country Club Rd Brevard, NC 28712/ 5010 Hendersonville Rd Fletcher NC 28732

119 Tunnel Rd Suite G Asheville NC 28805

phone: (828) 884-2475 email: intake@TapestryNC.com