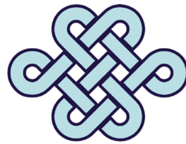

Tapestry

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: (888) 218-9797**********

11 N Country Club Rd Brevard, NC 28712/ 5010 Hendersonville Rd Fletcher NC 28732
119 Tunnel Rd Suite B Asheville NC 28805
phone: (828) 884-2475 email:intake@TapestryNC.com