Arkansas Families First

Providing Evidence-based Evaluation, Consultation, and Treatment

ARKANSAS FAMILIES FIRST: PATIENT REFERRAL FORM

Referring Professional:_____
Person to contact regarding referral:_____
Phone:_____

Patient Name:_____Age:_____
Parent/Guardian:_____
Phone:_____

Referral to:

_____Adam H. Benton, Ph.D.
_____Mary M. Ekdahl, Ph.D.
_____Paula Morse, L.P.C.
_____First available

Service(s) Requested:

_____Evaluation / Testing
_____Treatment

Presenting Concerns (include "rule out" diagnoses):

_____Behavior Problems
_____Attention Deficits
_____Depression
_____Anxiety
_____Learning Problems
_____Autism Spectrum Disorder
_____Other: _____

_____Trauma / Abuse or Neglect
_____Sexual Behavior Problems
_____Parent-Child Relational Problems
_____Social Skills
_____Grief / Loss
_____Anger / Impulse Control

Insurance Company: _____
Insurance Policy Number: _____
Insurance Policy Holder Name: _____
Policy Holder's Date of Birth: _____

Other requests / information: _____
_____
_____

Thank you for your referral!

4004 McCain Blvd., Suite 203, North Little Rock, AR 72116 Phone: 501-812-4268 Fax: 501-812-4286