



Cox Navigation Referral Form

Referring Agency Information

Referring Agency/Practice

Referring Individual/Provider Name

Phone (Required)

Fax

E-Mail

Preferred Method Of Contact

Patient Information

Patient Name

Date of Birth

Address

City

State

Zip Code

Phone

Alternate Phone

Parent or Guardian Name (if applicable)

Relationship

Patient Primary Insurance

Patient Secondary Insurance

Referral Information

Service(s) Requested

Therapy

Psychological Evaluation/Testing

Community Psychiatric Rehabilitation

Substance Use Treatment

Psychiatric Medication Evaluation and Stabilization

Psychiatric Medication Consult

Other

Current Mental Health Concerns/Symptoms

Clinical Documentation Included
(examples include: office notes,
lab work, medication list, etc.)

I have discussed this mental health
referral with patient/family, and they
are willing to participate in treatment.

A scheduling representative will work with your patient to coordinate the appointment. You will receive confirmation once the appointment is scheduled. To speak with your Burrell Referral Navigator, please call **417.761.5459** or email **CoxNavigationGroup@BurrellCenter.com**

Please fax or e-mail all documentation to the Burrell Referral Navigators

Fax: 417.761.5063

E-mail: CoxNavigationGroup@BurrellCenter.com