Provider Referral to The Orenda Center of Wellness

Date: _____ Provider: _____

Client Name: _____

Client DOB: _____ Client Phone Number: _____

Insurance provider: _____ MA#: _____ (if applicable)

Member ID & Group #: _____ Client SSN: _____

Referral Request:

Please provide information regarding; reason for referral, concerns, requests and recommendations:

Provider information:

Provider Agency: _____ Provider Level of Care: _____

Referral Signature: _____ Printed: _____

Provider Phone #: _____ Provider Email: _____

Providers please attach the following if available:

client's most recent diagnosis, most recent history and physical, current medication list, recent lab work, and any recent assessments.

Please fax this form to **240-366- 1851** *or email this form to* **Info@theorendacenter.com**
Follow up with your referral at 301-241-3629

Thank you!

Inpatient: 17645 Harbaugh Valley Rd. Sabillasville, MD 21780
Outpatient: 600 West Patrick St. Frederick, MD 21701
Phone Number: 301-241-3629 **Fax:** 240-366-1851
info@theorendacenter.com