Rowan Center for Behavioral Medicine

818-446-2522
consult@rowancenterla.com

Thank you for your interest in referring to the Rowan Center for Behavioral Medicine.
Please complete this form and fax it to 818-284-6368 or email to consult@rowancenterla.com.

Patient Name: _____

DOB: _____ **Phone:** _____

Patient insurance(s): _____

_____Patient will contact the center _____Please contact the patient directly

Referring Provider: _____

Reason for Referral: Please check as many as apply to provide our center with information regarding your patient's needs:

☐	ADHD/neurodivergence	☐	Insomnia/sleep Disorders
☐	Adjustment to chronic health condition (dx: _____)	☐	LGBTQIA+ concerns
☐	Anxiety	☐	Long Covid
☐	Cancer survivorship/support	☐	Panic disorder
☐	Caregiver support	☐	Relationship problems
☐	Chronic pain	☐	Specific phobia
☐	Coping with disability and changes In functioning	☐	Stress management
☐	Depression	☐	Trauma/PTSD
☐	End-of-life concerns	☐	Traumatic brain injury (TBI)
☐	Functional Neurologic/Motor Disorder (FND/FMD)	☐	Treatment adherence
☐	Grief	☐	Women's health
☐	Infertility and family planning	☐	Other: _____

We will assign providers based on their areas of expertise. If you have a specific provider preference please indicate here: _____

Preference for feedback regarding referral:

- ☐ Please contact referring provider via phone at _____
- ☐ Please fax a copy of the initial assessment to _____
- ☐ No need to provide specific feedback regarding referral
- ☐ Other preference regarding feedback _____

For questions regarding our services, please feel free to call **818-446-2522, ext. 1**.

We appreciate your referral and look forward to collaborating with you in the care of this patient.