PEGASUS Recovery Solutions

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REFERRAL FOR MEDICAL MONITORING

Date of Referral:	**Term of Agreement**:
Start Date:	**End Date**:
REFERRED BY	
Name:	**Organization**:
Phone:	**Email**:
CLIENT INFORMATION	
Name:	**Date of Birth**:
File/ID#:	**Position**:
Phone:	**Email**:
COMPLIANCE REPORTING	
Reporting Frequency - Weekly, Monthly or Quarterly:	
Reporting Method - Fax or Email:	**Password Protect**:
REPORTING RECIPIENTS	
Name:	**Organization**:
Fax:	**Email**:
Name:	**Organization**:
Fax:	**Email**:
Name:	**Organization**:
Fax:	**Email**:
Name:	**Organization**:
Fax:	**Email**:

MONITORING COSTS AND INVOICING	
Name:	**Organization**:
Fax:	**Email**:
Will costs be covered for the duration of contract?	
Date coverage complete:	**Coverage transferred to**:
REQUIRED DOCUMENTATION PLEASE FAX OR EMAIL PRIOR TO INTAKE APPOINTMENT	
• **Independent Medical Evaluation or Reevaluation**	
• **Completed referral form**	
• **Signed Consent to Release Information**	

To book intake appointment, please contact;

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