OFFICIAL FAX TRANSMISSION

TO: HEAL COLLABORATIVE

COMPANY/DEPARTMENT: PSYCHIATRY

RE: HEAL REFERRAL

FAX: (585) 276-1913  PHONE: (585) 275-HEAL

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FROM:

UNIT/DEPARTMENT/AGENCY:

FAX:  PHONE:

COMMENTS:

Please provide intake. The client would like to be contacted by:

☐ Phone

☐ Other:___________________________________________________________

* please call if the client would like to walk-in: (585) 275-HEAL

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