



OFFICIAL FAX TRANSMISSION

TO: HEAL COLLABORATIVE

COMPANY/DEPARTMENT: PSYCHIATRY

RE: HEAL REFERRAL

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FAX: (585) 276-1913

PHONE: (585) 275-HEAL

DATE:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY

FROM:

UNIT/DEPARTMENT:

FAX:

PHONE:

COMMENTS:

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

- ☐ Phone
- ☐ In-patient, nurses station contact: _____
- ☐ Other: _____

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

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