Healing Haven Hospital 





| **Patient Name:** | @name here |
| --- | --- |
| **Date of Birth** | January 30, 2030 |
| **Gender Assigned at Birth:** | Details here |
| **Address:** | 123 Anywhere St., Any City, ST |
| **Contact Information** | **Phone Number:** 123-456-7890 |
| **Email:** hello@reallygreatsite.com |



| Explain the reason for the patient or client’s referral. You may use bullet points to keep this section clear and concise. | |
| --- | --- |
| **Is this referral urgent?** | Yes/No |



| **Current Medications:** | * Medication, dosage, and schedule here * Medication, dosage, and schedule here * Medication, dosage, and schedule here |
| --- | --- |
| **Notable conditions:** | * Condition or diagnosis here * Condition or diagnosis here * Condition or diagnosis here |
|
|
| **Alcohol Consumption:** | ☐ Yes  ☐ No |
| **Drug Use:** | ☐ Yes  ☐ No |
| **Tobacco Use:** | ☐ Yes  ☐ No |



| Use this section to highlight any relevant observation or information related to the patient’s condition or diagnosis. |
| --- |

Signature here

**Referring Physician here Date:** January 30, 2030

