



OCH Behavioral Health Clinic
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FX (417) 823-2970

STAT ROUTINE

Patient Name: _____ DOB: _____ Age: _____

Contact PH #: _____ Guardian/POA: _____

Diagnosis/Reason for Referral:

In addition to this form, please attach the patient’s demographics, insurance information, office notes indicating the reason for referral, and any relevant lab results (if applicable).

Provider Signature

Date

Provider Name: _____

NPI: _____

Address: _____

Ph: _____

Fax: _____