Serenity Health LLC

Date:_____

Referring Patient to Which Provider:_____

Patient Name:_____

Patient Address:_____

Patient DOB:_____ **Patient Phone Number**:_____

Reason for Referral:_____

_____

_____

_____

Any History of Substance Use or Addiction: Yes_____ **No**_____

Any Special Care Needs: **Yes**_____ **No**_____

Medical History:_____

_____

Patient Records and Insurance Info Attached: **Yes**_____ **No**_____

Referring Physician Name:_____

Referring Physician Phone #:_____ **Fax #**_____

Signature:_____

Locations:

South County Office:
5000 Cedar Plaza Parkway
Suite 350
St. Louis, MO 63128
Fax: 314-214-7380

West County Office:
11477 Olde Cabin Road
(Temporary Location)
St. Louis, MO 63141
Fax: 314-866-2530

St. Peters Office:
4905 Mexico Road
Suite 300
St. Peters, Mo 63376
Fax: 636-626-2544