NEW LIFE MEDICINE

REFERRAL FORM

Referral Information

Patient:	DOB:	Phone:
Email:	Preferred Contact Name & Relationship:	
Address:		
Insurance Plan Name:	Insurance Policy ID:	

Referred For (check all that apply):

☐ Medication Assisted Treatment (MAT)

☐ Primary Care

☐ Psychiatric Evaluation & Treatment

☐ Other: _____

Patient's Preferred Practice Location:

☐ Johnson City ☐ Bristol, VA ☐ Richlands ☐ Castlewood ☐ Norton ☐ Abingdon

Referring Provider Information

Name:	Organization/Group Name:	Location:
Phone:	Fax:	Email:

Comments:

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Johnson City: 2408 Susannah St Ste 1, Johnson City, TN 37601 | Phone: (423) 434-6677 | Fax: (423) 461-0000

Bristol, VA: 1662 Bonham Road, Bristol, VA 24201 | Phone: (276) 644-9899 | Fax: (276) 644-9978

Richlands: 2011 2nd Street, Richlands, VA 24641 | Phone: (276) 345-9900 | (276) 345-9901

Castlewood: 19380 US Hwy 58, Castlewood, VA 24224 | Phone: (276) 762-2172 | Fax: (276) 762-5039

Norton: 1725 Park Ave SW, Norton, VA 24273 | Phone: (276) 409-5922 | Fax: (276) 409-5923

Abingdon: 137 Court St SE, Abingdon, VA 24210 | Phone: (276) 477-1400 | (276) 477-1401

www.newlifemedicinegroup.com