NORTH AMERICAN MENTAL HEALTH SERVICES

MENTAL HEALTH REFERRAL FORM

Legal Name: _____ Preferred Name: _____

Preferred Pronouns: _____ Sex: ☐ M ☐ F DOB: _____

Preferred Language: _____ Translator Needed? ☐ Yes ☐ No

Guardian/Conservator (if Applicable): _____

Address (Physical): _____

City: _____ State: _____ Zip Code: _____

Address (Mailing): _____

City: _____ State: _____ Zip Code: _____

Phone Number (primary): _____ *(Alternate)*: _____

Email Address: _____

Insurance Carrier: _____ Member Policy #: _____

Name of Insured: _____ DOB: _____

Relationship to Patient: _____

Secondary Insurance: _____ Policy#: _____

Has patient been informed that provider is referring them to a mental health provider?

☐ Yes ☐ No

Reason for referral: ☐ Medication Management (Psychiatry) ☐ Therapy

Which location would you like to be seen at?

☐ Redding ☐ Red Bluff ☐ Eureka ☐ Fairfield ☐ Monterey ☐ Salinas ☐ Hollister

☐ HomePsych *(online)*

Referring Provider/Clinic: _____

Phone: _____ Fax: _____

Form Completed By: _____ Date: _____

Please Fax Completed Form to NAMHS Centralized Scheduling at **(530) 722-4544**
1742 Oregon Street, Redding, CA 96001
Phone: 1 (888) 292-8080 || **Email:** appointment@namhs.com