North American Mental Health Services

Mental Health Referral

Patient Name: _____ Sex: ☐M ☐F DOB:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Best Phone Number: _____

Alternate Phone Number: _____

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 ☐Telehealth

Explanation of Patient's Mental Health Diagnosis or Symptoms:

Current Medications:

Preferred Pharmacy: _____

Referring Provider/Clinic: _____

Phone: _____ Fax: _____

Form Completed By: _____

Please Fax Completed Form to (530) 275-2201

Redding: 1742 Oregon St. • Redding, CA 96001 • Phone: (530) 646-7269 • Fax: (530) 275-2201
Woodland: 255 W. Court St. Ste D • Woodland, CA 95695 • Phone: (530) 406-7993 • Fax: (530) 406-7996