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 Explanatio

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) 722-4544

Redding • Woodland • Eureka • Fairfield
Phone: (530) 226-0375 • Fax: (530) 722-4544