North American Mental Health Services

# Mental Health Referral

Legal Name: _____ Preferred Name: _____

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

Guardian/Conservator (if Applicable) _____

Address (No P.O. Box - Physical 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

Referring Provider/Clinic: _____

Phone: _____ Fax: _____

Form Completed By: _____

*Please Fax Completed Form to **(530) 722-4544** or Email to **referrals@namhs.com***