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: __________

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

Which location would you like to be seen at?

☐ Redding ☐ Eureka ☐ Woodland ☐ Fairfield ☐ Salinas ☐ Monterey ☐ HomePsych (online)

Referring Provider/Clinic: ______________________

Phone: ______________________ Fax: ______________________

Form Completed By: ______________________

Please Fax Completed Form to NAMHS Centralized Scheduling at **(530) 722.4544**

2400 Washington Ave, Suite 201B, Redding, CA 96001 | Phone: +1 (888) 292.8080
Email: appointment@namhs.com