



# 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

Red Bluff  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](mailto:appointment@namhs.com)**