



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 Red Bluff Eureka Woodland Fairfield Monterey
- Salinas Hollister HomePsych (online) New Life Discovery (Satellite Location)

Referring Provider/Clinic: _____

Phone: _____ Fax: _____

Form Completed By: _____

Please Fax Completed Form to NAMHS Centralized Scheduling at **(530) 722.4544**
1742 Oregon Street, Redding, CA 96001 | Phone: +1 (888) 292.8080
Email: appointment@namhs.com