Community Psychiatry

MENTAL HEALTH REFERRAL

Patient Name: _____ **Sex:** ☐ M ☐ F **DOB:** _____

Address: _____ **City:** _____ **Zip Code:** _____

Best Phone Number: _____

Please check appropriate box to indicate patient's insurance (we accept the plans listed below):

- ☐ Aetna
- ☐ Anthem Blue Cross / PPO
- ☐ Anthem Blue Cross / Medi-Cal
- ☐ Beacon
- ☐ Blue Shield (MHSA)
- ☐ Health Net/MHN-Group # _____
- ☐ HMC Health
- ☐ Humana
- ☐ Magellan/WHA Works
- ☐ UBH
- ☐ Other_____

Member Policy #: _____

Name of Insured: _____ **DOB** _____

Relationship to patient: _____

Preferred Community Psychiatry Location(s): _____

Has patient been informed that provider is referring them to a psychiatrist? ☐ Yes ☐ No

Provider Preference: ☐ No Credential Preference ☐ Psychiatric Nurse Practitioner ☐ Psychiatrist ☐ No Gender Preference ☐ Male ☐ Female

Reason for Referral: ☐ Medication Management ☐ Psychiatric Evaluation

Note: We do not accept workers compensation or disability evaluations

Explanation of Patient's Mental Health Diagnosis or Symptoms:

Current Medications:

Patient Mental Acuity: ☹ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) ☺

Referring Provider: _____ **Phone:** _____

Form Completed By: _____ **Fax:** _____

Please fax completed form to 833-261-5345