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)
☐ Cigna
☐ 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
or email completed from to intakeref@cpsych.com