COMMUNITY REFERRAL FORM
FOR MENTAL HEALTH SERVICES

Date: ____________________

Name (First, Last):_________________________________ **Preferred Name**: ________________

Date of Birth:___________________ **Age**:______ **Social Security #**:______________________

Preferred Gender: ❑ Male ❑ Female ❑ Non-Binary ❑ Prefer not to disclose ❑ Different Identity:______

Pronouns: ❑ He/Him ❑ She/Her ❑ They/them ❑ Unlisted **Active Military/Veteran**: ❑ Yes ❑ No

Racial/Ethnic Identity (check all that apply):

❑ Asian
❑ Black or African American
❑ Middle Eastern/North African
❑ Hispanic, Latino/a/x - Cuban
❑ Hispanic, Latino/a/x – Mexican
❑ Hispanic, Latino/a/x – Puerto Rican
❑ White
❑ Other: ___________
❑ Unknown

Preferred Language:____________________________ **Does client prefer a therapist based on preferred language?** ❑ Yes ❑ No

Address:____

Apt #: City: Zip:

Phone #:______________________________ **Is it OK to leave a message?** ❑ Yes ❑ No

Reasons for referral: ____

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Are they in therapy elsewhere? ❑ Yes ❑ No **If yes, with whom:**_________________________________

Are they currently on medication? ❑ Yes ❑ No **If yes, who is prescribing Dr.**:_______________________

Insurance Information:

Insurance Provider: ____________________ **ID #:**____________________**Group #:**________________

Medicaid #:_______________ **Medicare #:**_______________

Emergency Contact Information (optional):

Name:_________________________ **Phone #:**______________________ **Relationship:**_____________

REFERRAL SOURCE

Name: _________________________________ Phone: ____________________ Fax: ____________________

Please email completed form to:

Zaneta Evans zaneta.evans@mhcd.org

INTERNAL USE ONLY:

Date Referral Received: ________________________ Date Assigned: ________________________________

Therapist Assigned:___________________________ First Scheduled Apt:_____________________________