Mental Health Referral Form

Heart-Centered Counseling

Who is making the referral?

Name of Clinic/Office Making the Referral

Parent Organization (if applicable)

Name of Provider/Referrer (e.g., Dr. James Jones)

Clinic Phone Clinic Fax

Date of Referral

Who is the referral for?

Client Information (Basic)

Client Name Client Date of Birth

Client Information (Contact)

Client Phone Number: Primary Cell Home

Patient to be seen: in the home via tele-health. / at HCC office / at clinic via tele-med

Client Screened for needed technology? Yes No

Tele-health consent form signed? Yes No

List of regional emergency services attached? Yes No

Client Information (Additional):

Presenting issue Mental Health Substance Abuse Psychiatry
(Circle one of more)

Brief Comment about client's struggles/diagnosis (optional):

Include insurance card copy or complete insurance information (whenever possible).

Email to help@heartcenteredcounselors.com or fax to 888-965-4615