Mental Health Services Referral Form

Please fax Referral Form to Central Scheduling at: (989)479-5014

Referral Source Information

Organization Name:____

Contact Person:____

Phone:____

Fax:____

Patient Referral Information

Name:____

Phone:____

Date of Birth:____

Social Security Number: ____

Insurance Primary:____

Insurance Secondary:____

Mental Health Service

☐Outpatient Therapy

☐Tele-Psychiatry

If tele-psychiatry, please check all that apply:

☐ Child (Ages 2 - 18)

☐ Adult (Ages 18 - 65)

☐Senior Citizens (Ages 65 +)

The provider has my permission to send this referral as well as coordinate and exchange information with Harbor Beach Community Hospital for mental health services.

Patient Signature:____________________________________ Date:_________________

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