Mended Hearts Counseling & Recovery Solutions
Reviving Hope Releasing Hurt

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To maintain HIPPA compliance, please fax referral form to 888-972-4985.

You may attach Medicaid/Insurance card .

Referral Form

Date of Referral: _____

Patient Name: _____

Patient Gender: _____ Birth Date: _____

Address: _____

Patient Telephone(s): Cell: _____ Home: _____ Ok to leave message? _____

Reason for Referral/Presenting Problem: _____

_____

_____

_____

_____

Current Medications, if any: _____

_____

Additional Comments: _____

_____

_____

_____

Referring Physician/Professional (please complete or use stamp and include individuals name making referral):

Name:

Telephone:

Address:

The above client is referred to MHCRS for outpatient individual/family mental health therapy. Treatment is medically necessary for the client.

Signed:_____ Title:_____

Many thanks for your referral!!

Office Use Only:

Date referral received:_____ Action taken:_____