PO Box 16181 High Point NC 27261
Phone: 336-609-7383 Fax: 888-972-4985
enjonae@mhcrs.com www.mhcrs.com

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:

Signed: ______________________________

Many thanks for your referral!!
Office Use Only:
Date referral received:____________________Action taken:____________________