ROOTED+VITALITY HEALTH COLLABORATIVE

A Psychological Corporation

Client Referral Form for Mental Health Services

Demographic Information:

Client Name: _____ DOB: _____

Sex: ☐ Male ☐ Female [required for insurance claims]

Gender Identity and Preferred Pronouns: _____

Phone Number: _____ Email: _____

Is it okay to call? ☐ Yes ☐ No It is okay to email? ☐ Yes ☐ No

May we leave a message? ☐ Yes ☐ No

Is it okay to text? ☐ Yes ☐ No

Address: _____

City: _____State: _____ Zip Code: _____

Insurance Information:

Insurance Carrier: _____

Member Policy #: _____

Name of Insured: _____

Relationship to Client: _____

Secondary Insurance: _____

Member Policy #: _____

Reason for Referral:

Please provide an explanation of Client's Mental Health Diagnosis or Symptoms

_____

_____

_____

Has the client been informed that the provider is referring them to a mental health provider? ☐ Yes ☐ No

Referring Provider/Clinic: _____

Phone: _____ Fax: _____

Form Completed By: _____

Thank you for your referral!

Please fax completed form to 559-494-4831 or email to info@rootedvitalityhealth.com

Rooted+Vitality Health Collaborative
516 W. Shaw Ave., Suite 200
Fresno, CA 93704

Phone: 559.221.2584
Fax: 559.494.4831
Email: info@rootedvitalityhealth.com