Promise Healthcare

Mental Health Wellness Referral

Please complete the below information

Date: _____/_____/_____

To: Promise Healthcare Mental Health Wellness

Attention: New Patient Referrals

Email: mentalhealthwellness@ promisehealth.org

From: _____

Contact Information: _____

Patient Name: _____ **Date of Birth:** _____/_____/_____

Grade: _____ **Insurance Provider (if known):** _____

Parent or Guardian name (s): _____
(**Parent info not required if 12 years or older and do not wish for parents to be informed)**

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone number: _____ **(home, cell, other) Email:** _____

Notes: _____

_____

_____

_____

_____

_____

_____

STAFF USE ONLY

Received by: _____ **Date Received:** _____/_____/_____