IHEARU
MENTAL HEALTH

REFERRAL FORM

Date: _____
Client Name: _____
Client Telephone Number: _____
Referring Person's Name: _____

Client's POA, Guardian or Healthcare Surrogate, Name & Telephone Number (if applicable):

_____

Reason for Referral:

_____
_____
_____

TeleMental Health Therapy?

Yes___ No___

If yes, please provide patients direct phone number: _____

Please fax or e-mail:

- Client Referral Form
- Photo copies of Clients' insurance cards (front and back)
- Other pertinent clinical information

Fax: (214) 764-3312 | E-mail: info@ihearumentalhealth.com