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:_____

Student 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:_____

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STAFF USE ONLY

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