



THR MENTAL HEALTH CLINIC

Mental Health REFERRAL FORM

1011 University Boulevard
Suite #101
Silver Spring, MD 20903

Tel #: (301) 439-7200
Fax #: (301) 439-5556
www.thresources.org

MON-THU: 11am to 8pm
FRI: 11am to 2pm
SAT-SUN: closed

INSTRUCTIONS: [1] Type referral data into fields; [2] Print completed form, & [3] Fax or mail to THR Health Clinic.

I. CLIENT INFORMATION:

| | | |
|---|--------------------|--|
| CLIENT NAME: | | REFERRAL DATE: |
| DATE OF BIRTH: | AGE: | GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| PLACE OF BIRTH: | LANGUAGE SPOKEN: | |
| ADDRESS: <i>Street Address</i> <i>City</i> <i>State</i> <i>Zip Code</i> | | |
| HOME PHONE: | CEL PHONE: | BEST TIME TO CALL: <input type="checkbox"/> am <input type="checkbox"/> pm |
| DOES CLIENT HAVE INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No | INSURANCE CARRIER: | POLICY #: |

II. EMERGENCY INFORMATION:

| | |
|-------------------------------------|---------------------------------|
| IN THE EVENT OF EMERGENCY, CONTACT: | RELATIONSHIP: |
| EMERGENCY CONTACT'S HOME PHONE: | EMERGENCY CONTACT'S WORK PHONE: |

III. DETAILED REFERRAL INFORMATION:

REASON FOR REFERRAL:

IV. REFERRER :

| | |
|--|-------------------|
| REFERRED BY: | REFERRER'S PHONE: |
| REFERRER'S ADDRESS: <i>Street Address</i> <i>City</i> <i>State</i> <i>Zip Code</i> | |

-- CONFIDENTIAL AND PRIVILEGED COMMUNICATION --

This form and all attachments, if any, contain legally privileged and/or confidential information. If you are not the intended recipient, you are hereby notified that any dissemination, distribution or copying this form, or any of its content or attachments, is strictly prohibited. If you have received this form in error, please immediately telephone the THR MENTAL HEALTH CLINIC in the USA at 301-439-7200 and permanently delete the original and any attachments.