Montani Mental Health

1137 Van Voorhis Road, Unit 44 Up
Morgantown, WV 26505
Phone: 304-282-0588

NEW PATIENT REFERRAL FORM

Date of Referral: _____ Employee Initials: _____

Referring Doctor/Source: _____

Referral Source Phone: _____ Fax: _____

Referral Source Email: _____

PATIENT INFORMATION

Patient Name: _____ □Male □Female

Patient's Legal Guardian (*if minor*): _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Patient's Social Security #: _____ DOB: _____ Age: _____

Home phone: _____ Cell phone: _____

Patient Email address: _____

Has the patient received mental health services before (e.g. from a psychiatrist, therapist or psychologist)? Please indicate which provider and when services were received:

_____

_____

What are the patient's current symptoms? _____

_____

How long have these symptoms bothered the patient? _____

_____

Current medications:

_____

INSURANCE INFORMATION

A copy of the front and back of the insurance card is required*

Primary insurance: _____

Customer service number: _____

Identification number: _____

Group number: _____

Name of policyholder: _____

Relationship to patient: _____ DOB of policyholder: _____

SS# of policyholder: _____ Employer: _____

WE DO NOT PARTICIPATE IN ANY FORM OF MEDICAID.

PLEASE NOTE: Our office will make two attempts to contact the patient to schedule an appointment. After two attempts have been made, it is the patient's responsibility to contact the office to schedule an appointment.

THANK YOU FOR THIS REFERRAL!