HERKIMER COUNTY MENTAL HEALTH SERVICES

REFERRAL FORM

Patient Name: _____

Last First **Maiden/Other**

Address: _____

Box/Apt. # Street Village/Town Zip Code

Phone#: ( ) _____-_____ Date of Birth: ___/___/_____ Age: ___**Social Security #** _____-_____-_____

Email Address: _____

Has patient ever been here before? _____ If so, under the same name? _____

Payment Source: Insurance _____ID#_____

Do you have a worker's compensation case open? _____ Policy/Case#: _____

Reason for Referral: (***Include Office Notes Indicating Need, Health Issues, List of All Medications, and Most Recent Lab Results***)

_____

_____

_____

_____

***REFERRED BY*:**

Name: _____ Agency: _____

Address: _____

Phone #: ( ) _____-_____ Fax: ( ) _____ - _____ Date: _____/_____/_____

*PLEASE MAIL OR FAX REFERRAL FORM AND REQUIRED INFORMATION TO:

Herkimer County Mental Health Services

Suite 2470, 301 N. Washington Street

Herkimer, NY 13350

Phone: (315) 867-1465

Fax: (315) 867-1469

Rev 05/2021