Pacific Mental Health Services

Patient Referral Form

LICENSED TELEHEALTH · ALL 58 CA COUNTIES
(925) 771-0430 · WWW.PACMHS.COM

SCAN TO REFER ONLINE

Complete this form and email it to **dkolpacoff@pacmhs.com** for manual processing, or scan the QR code to submit online at **www.pacmhs.com/connect**. Either way, expect a response within **12–24 hours**. No referral is required for patients to self-refer.

1 · PATIENT INFORMATION

First Name _____ Last Name _____

Date of Birth _____ County of Residence _____

Phone _____ Email _____

How to reach the patient: ☐ Phone Call ☐ Text ☐ Email

Best time to reach: ☐ Morning ☐ Afternoon ☐ Evening

2 · REASON FOR REFERRAL — select up to 3

☐ Anxiety ☐ Depression ☐ Trauma / PTSD ☐ Grief & Loss
☐ ADHD / Executive Function ☐ Life Transitions ☐ Relationship Issues ☐ Couples Counseling
☐ Family Conflict ☐ Teen / Child Therapy ☐ Self-Esteem & Identity ☐ LGBTQ+ Support
☐ Anger Management ☐ Substance Use ☐ Court-Ordered Therapy ☐ Domestic Violence
☐ Work Stress & Burnout ☐ OCD ☐ Sleep Issues ☐ Postpartum & Perinatal

Other / clinical notes _____

3 · INSURANCE

☐ Partnership HealthPlan (Medi-Cal) ☐ Medi-Cal — other / not sure ☐ Medicare ☐ Medi-Medi ☐ Private Pay
☐ Other / Not Sure

PHP members typically pay nothing for covered sessions — no referral or prior authorization required. We verify all benefits before the first appointment.

4 · REFERRING PROVIDER

Provider Name & Credentials _____ Organization / Practice _____

Phone _____ Email _____

☐ The patient has consented to this referral, understands PMHS is a telehealth-only practice, and will be physically located in California at the time of each session.

Signature _____ Date _____