MindFlow Mental Health
824 E Jackson St. Suite A, Medford OR, 97504 | Phone: 458-488-1000 | Fax: 458-488-1001

Referral Form

Please complete this form in its entirety, to the best of your ability and include a copy of both the front and back of all insurance cards you would like to use. Once received the form will be reviewed by the provider requested on the referral form and the billing information will be sent to Pivot Billing to verify benefits and provide you with a good faith estimate of what care at MindFlow Mental Health will cost for you. If the requested provider agrees to establish care, someone from MindFlow Mental Health will reach out to schedule an appointment and establish portal access where you can complete the intake paperwork. If there are any questions don't hesitate to reach out, we are here to help.

Please send completed paperwork via snail mail, hand delivery, fax, or encrypted email to:

MindFlow Mental Health

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Medford, OR. 97504

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If you are a care provider and referring your client for services, please include the most recent chart notes and labs (CBC, CMP, vitamin D, thyroid panel, cholesterol panel, B vitamin levels, autoimmune testing, CRP, Insulin, glucose, HbA1c, ferritin, folate, Iron & TIBC, homocysteine, steroid hormones, ekg, etc.).

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CLIENT INFORMATION

Clients Full name, including middle: _____

Client's preferred nickname, if any: _____

Client's full address: _____

Client's phone number (adolescent's phone number if over 13): _____

Client's email address: _____

Client's preferred pronouns: _____

Client's sex at birth: _____

Client's gender: _____

Client's ethnicity: _____

Client's preferred language: _____

PARENT'S INFORMATION (if applicable)

Mom's full name, including middle: _____

Mom's full address: _____

Mom's phone number: _____

Mom's email address: _____

Mom's sex at birth: _____

Mom's gender: _____

Dad's full name, including middle: _____

Dad's full address: _____

Dad's phone number: _____

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Dad's email address: _____

Dad's sex at birth: _____

Dad's gender: _____

PRIMARY INSURANCE INFORMATION

Name of insurance company: _____

Member ID: _____

Group ID: _____

Plan ID: _____

Primary policy holder's full name, including middle: _____

Policy holder's full address: _____

Policy holder's phone number: _____

Policy holder's sex: _____

Policy holder's date of birth: _____

SECONDARY INSURANCE INFORMATION (if applicable)

Name of insurance company: _____

Member ID: _____

Group ID: _____

Plan ID: _____

Secondary policy holder's full name, including middle: _____

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Policy holder's full address: _____

Policy holder's phone number: _____

Policy holder's sex: _____

Policy holder's date of birth: _____

REASONS FOR SEEKING CARE

What provider are you seeking a referral to? _____

Please provide a detailed description of why you/client is seeking mental health care or you are referring this person for care: _____

_____

_____

_____

_____

What are your goals for working with a MindFlow Mental Health provider?

1.) _____

2.) _____

3.) _____

Are you seeking mediation, therapy, or both? _____

Please list any currently prescribed mental health medications: _____

_____

_____

_____

_____

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Please list all past mental health medications, dates of use, and who prescribed: _____

Please any current psychotherapists name, date, and concerns being treating: _____

Please list all past psychotherapists, dates, concerns treated, and effectiveness: _____

Have you recently been hospitalized or sought emergency care for any mental health concern? If yes, what was the outcome? _____

Please list any past mental health hospitalizations, name of facility, date(s), and reason(s) for admission: _____