HELIOS
PSYCHIATRY & COUNSELING

REFERRAL FORM

PATIENT INFORMATION

Name: _____

Address: _____

DOB: _____Phone: ( )_____

Email address for adult: _____

If the Patient is a minor (under the age of 18), please provide information for the parent or legal guardian.

Parent/Legal Guardian Name: _____ Relationship: _____

If guardian, we will need Legal Guardianship documents.

INSURANCE INFORMATION

Insurance: _____ID#_____

Group#_____

Policy Holder's Name: _____Policy Holder DOB: _____

Relationship to Patient: _____ Additional insurance: Y _____ N ____

Additional Information:

Reason for referral: _____

_____

Contact information for person referring: _____

Revised 7-19-2024

Return Completed Form To: Fax - 586-863-4004 Or Email - intake@heliospsych.com

Patient can also complete Intake packet through our website www.heliospsych.com