Tri-City Mental Health Center – Intensive Outreach and Engagement Team

General Referral Form

Name: _____ **DOB:** _____

_____ (initial) I wish to consider or engage in mental health treatment at Tri City Mental Health Center.
(I understand that someone from Tri City will attempt to contact me regarding services).

_____ (initial) I understand that a referral to Tri-City Mental Health Center does not necessarily mean I will qualify for services.

_____ _____
Signature **Date**

Street Address: _____**City:** _____
Check here □ if homeless.

Phone Number: _____ **Preferred Language(s):** _____

Best Way to Contact (ex. Phone, In-Person, Home, Public Location?): _____

Ethnicity:	**Gender:**
□ White/Caucasian □ Black/African American □ Hispanic/Latino □ Asian/Pacific Islander □ Other	□ Male □ Female □ Transgender

Presenting Concerns:

Person Completing Form/Contact #: _____

*Please call **(909) 762-1006**, Monday-Friday, 8:30 AM-5:00 PM for any referral questions.*
When complete, please fax form to Tri-City Outreach & Engagement Team (909) 865-9281