National Alliance on Mental Illness
New York City Metro

RAPID REFERRAL

NO COVER SHEET NECESSARY!

DATE: _____

EMAIL TO: **NAMI NYC Helpline**
EMAIL: **referral@naminyc.org**

Name of the person being referred: _____
(Please PRINT first and last name)

Telephone number of the person being referred: _____

This person's relationship to the person living with a mental health condition:
☐Self ☐Spouse/Partner ☐Parent ☐Sibling ☐Friend
☐Other: _____

Best time to call: ☐Morning ☐Afternoon ☐Early Evening
Preferred language: ☐English ☐Spanish ☐Other: _____

I give permission to my healthcare or other service provider to give my name, contact information, and protected health information to NAMI NYC. I understand that a NAMI NYC Helpline volunteer or staff person will contact me about the free support and educational services that are available. I understand that my name, contact information and other information listed below will not be disclosed or shared with any other entity unless authorization is obtained by me. I understand that I can revoke my permission at any time by contacting the referring provider named below.

I give permission to NAMI NYC to follow up with the provider named below.

Signature: _____ Date: _____ ***must be signature of person being referred***

☐Providers who have received verbal consent from the individual being referred should check this box to attest to having received this consent in lieu of obtaining a signature.

TO BE COMPLETED BY REFERRING PROVIDER

Provider Name: _____

Provider Signature: _____ Date: _____

Provider Organization: _____

Provider Phone: _____ Provider Email: _____

Reason for referral: *(please check all that apply)*: ☐Education Classes ☐Support Groups ☐Parent Match ☐Basic Information

NAMI INTERNAL USE ONLY

Initials: _____ Date: _____ ☐Packet sent Date: _____

☐F2F ☐P2P ☐HF ☐H4R ☐B ☐SG ☐PM ☐Basic info ☐Provider F/U Date: _____