



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)

Age of the person being referred: _____

Telephone number of person being referred: _____ Email address of 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*

TO BE COMPLETED BY REFERRING PROVIDER	
Provider Name: _____	
Provider Signature: _____ Date: _____	
Provider Organization: _____	
Provider Phone: _____	Provider Email: _____
Reason for referral: <i>(please check all that apply)</i> :	
<input type="checkbox"/> Education Classes	<input type="checkbox"/> Support Groups
<input type="checkbox"/> Parent Match	<input type="checkbox"/> Basic Information

NAMI INTERNAL USE ONLY			
Initials: _____	Date: _____	<input type="checkbox"/> Packet sent	Date: _____
<input type="checkbox"/> F2F <input type="checkbox"/> P2P <input type="checkbox"/> HF <input type="checkbox"/> H4R <input type="checkbox"/> B	<input type="checkbox"/> SG <input type="checkbox"/> PM	<input type="checkbox"/> Basic info	<input type="checkbox"/> Provider F/U Date: _____