Light Mental Health, LLC
Services

P - 978-545-1442
Fax - 978-545-1552

Additional forms can be found under Referrals at:

www.light-mh.com

Referral Form: (please fax completed form)

Please Print Clearly: **Date of Request:**

Person Served Name:	DOB.	Preferred
Address:	Phone #: (Cell)	(Home)
E-mail/Other:	Social Security Number:	
Guardian (if applicable):		
Contact for intake (Name & Relationship): Phone: Email:		
Referred by:	Name of Site	eMail: Phone:

Primary Insurance Type

Plan Type: ___ Individual ___ Family. ___ NONE

Policy Number:

Subscriber Name:

Subscriber Address:

Secondary Insurance Type:

Plan Type: ___ Individual ___ Family. ___ NONE

Policy Number:

Subscriber Name:

Subscriber Address:

Dates / Location of Recent Admission(s) if known:

Diagnosis

Substance Use Diagnosis: