Tennessee Mental Health Consumers' Association

Please email or fax to

bhuffman@tmhca-tn.org

901-522-2099

Date: | TennCare #

Referral Name:

Date of Birth: | Social Security #: | Sex:

Street Address:

City/Zip: | Phone:

Emergency Contact Name:

Relationship | Phone:

Primary Care Physician: | PCP Phone#

Community Residence (Check Appropriate)
☐ independent ☐ w/family ☐ homeless
☐ supported living facility ☐ other provider

Current Primary DSM V Diagnosis

Referral Source:

Agency: | Name:

Address/ City/ Zip:

Title: | email: