External Referral Form

Please Email:referral@centermh.org or Fax: 970-252-3208: Attn: Medical Records Coordinator

Date: ____________ Name of Agency Referring: ______________ Office Phone #: ________________

Client Name: ________________________________ Client Date of Birth:___________________

Guardian Name (if minor): ____________________ Contact Phone Number _________________________

Preferred language ☐ English ☐ Spanish ☐ Other ________________________

Client is aware and Understands Reason for Referral? ☐ Yes ☐ No

Client Gives Permission for CMH to follow up on Referral? ☐ Yes ☐ No

Are you referring for Mental Health Services ☐ Yes ☐ No

Substance Use Treatment ☐ Yes ☐ No

Psychiatric Services ☐ Yes ☐ No

Release of Information attached: ☐ Yes ☐ No

Positive Depression Screening: ☐ Yes ☐ No Date of Screening _________________

TO FACILITATE CARE:

- **Please send *only the following*:**
  - **Most recent visit note**
  - **Most recent physical examination, including any ICD-10 diagnoses**
  - **Most recent lab results**
  - **Current Medication list**
  - **Release of Information**
  - **Other** ____
- **Medicaid EPSDT: If this is a MEDICAID client under age 21, please also send a copy of the client's most recent EPSDT screening.**

Reason for Referral:

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- PLEASE CALL THE NEAREST LOCATION FOR WALK IN HOURS

Location	Phone	Location
Delta	(970) 874-8981	107 W 11th St, Delta, CO 81416
Gunnison	(970) 641-0229	710 N. Taylor St, Gunnison, CO 81230
Montrose	(970) 249-9694	605 E Miami, Montrose, CO 81401
Norwood	(970) 327-4449	1175 Grand Ave, Norwood, CO 81423
Ridgway	(970) 497-5742	177 Sherman St, Ridgway, CO 81432

30-day Disposition: ____

Note: The referring agency will be contacted within thirty (30) days with regards to disposition of the referral.

FOR ANY EMERGENCY OR CRISIS NEEDS PLEASE CALL 970-252-6220. Please use this form only for referrals and not immediate mental health needs.

Reviewed 1/4/2019