THE CENTER for Mental Health

External Referral Form

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

Date: _____ Name of Referring Agency/Person: _____ Office Phone #: _____

Client Name: _____ Client Date of Birth: _____

Guardian Name (if minor): _____ Contact Phone Number _____

Insurance/Payor type: _____ Primary Care Provider _____

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	☐ Yes	☐ No
	DUI	☐ Yes	☐ No
	DUI 4+	☐ Yes	☐ No
	Substance Use Treatment	☐ Yes	☐ No
	Intensive Outpatient Program	☐ Yes	☐ No
	Psychiatric Services	☐ Yes	☐ No
	Psychological Testing	☐ Yes	☐ No
	OP Restorative (OREST)	☐ Yes	☐ No
	Vocational Rehab	☐ 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:

_____

_____

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 11/20/2020