MIND SPRINGS *health*

Referrals Fax Line: 970.683.7235

OR

Encrypted Email address only: OutpatientReferrals@MindSpringsHealth.org

If this is an emergency, please call West Springs Hospital Expedited Admissions at 970.201.4299

Individual Information

Name:

If minor,
Name of parent or guardian:

Address:

Phone:	Cell:	Date of Birth:

Preferred language if not English:

Referral Source Information

Referring Agency:	Date of Referral:

Your Name:

Phone:	Fax:	Release Signed? ☐ Yes ☐ No

Why is this client being referred?

☐ Therapy ☐ Medication Management ☐ Diagnostic Clarification ☐ Not Sure

Behaviors / Concerns:

☐ Psychosis ☐ Suicidality ☐ SUD ☐ Mood Disorder ☐ Medication Assisted Treatment

☐ Other

Other Relevant Information / Explanation:

Does individual have:

☐ Medicaid Insurance

☐ Private Insurance Name:

Please provide most recent list of medications and any relevant notes or labs

If applicable, are records attached? ☐ Yes ☐ No

INTERNAL USE ONLY
Referral Status

Date Referral received by MSH:	MSH Initials:
Appointment Scheduled: Yes ☐ No ☐	Appointment Kept: Yes ☐ No ☐
Outreach Attempt: Date Time	No Response ☐ Declined Referral ☐