MIND SPRINGS *health*

Referrals Fax Line: 970.683.7235

OR

Encrypted Email address only: OutpatientReferrals@MindSpringsHealth.org

If this is an emergency, please call our crisis line at 1-888-207-4004.

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 ☐