



**Walden Office**

**Please Fax this Form to 970.723.4732**

If you do not hear back from Mind Springs Health, either we did not see this individual, or we did not receive a Release of Information that allows us to contact you.

**IF THIS IS AN EMERGENCY, PLEASE CALL:**  
 West Springs Hospital 24/7 Assessment & Admissions Team at **970.201.4299** or  
 Colorado Crisis Services 24/7 Mobile Crisis Hotline at **844.493.8255**

**Individual Information**

Name		
If minor, Name of Parent or Guardian		
Address		
Phone	Cell	Date of Birth

**Referral Source Information**

Referring Agency	Date of Referral	
Your Name		
Phone	Fax	Release Signed? <input type="checkbox"/> Yes <input type="checkbox"/> No

Why is this client being referred?

Observed Behaviors: Mental Health/Substance Abuse concerns:

What are you hoping this individual will get at Mind Springs Health?

Will referring agency be paying for the service?  Yes  No

Is authorization attached?  Yes  No

**Mind Springs Health and Individual Plan**

<input type="checkbox"/> Assessment only, or:	
Services Offered:	
Clinician Providing Services:	
Frequency/Duration	Agreed upon with Individual