



Please Fax this form to 970-683-7272

- If this is an emergency, please call our crisis line at 970-241-6022. If you also wish to send information to the crisis team on this form fax the form to 970-683-7279.
• If you do not hear back from Colorado West Regional Mental Health, either we did not see this individual, or we did not receive a Release of Information that allows us to contact you.

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? Yes No

Why is this client being referred?

Observed Behaviors: Mental Health / Substance Abuse concerns:

What are you hoping this individual will get at Colorado West Regional Mental Health?

If referral includes medical services please attach the following:

- Complete Medication list
Recent lab results
Last 3 (pertinent) medical progress notes.

Colorado West and Individual Plan

Assessment only, or:
Services Offered:
Clinician Providing Services:
Frequency/Duration Agreed upon with Individual