COMMUNITY REACH CENTER

REFERRAL FORM - BEHAVIORAL HEALTH SERVICES

Please check if this is a referral to **Community Reach Center** for:

- ☐ An intake assessment for children ages 0-8
- ☐ An intake assessment for an individual over the age of 8

Please fax this form to: Intake Services Manager at 303-487-7240

First Name: _____ Last Name: _____

DOB: _____ Male ○ Female ○

Medicaid ID #_____ Other Insurance: _____

(Foster) Parent or Guardian Name (if applicable)

_____

Address:

_____

City: _____ State: _____ Zip: _____ County: _____

Phone #: _____

Primary Language Spoken: English ○ Spanish ○ Other_____

Referring Organization/Program Name:

_____

Referring Provider Name:

_____

Referring Organization Address:

_____

City: _____ Phone #: _____Fax #: _____

What concerns caused this referral?

_____

_____

_____

_____

_____

Medical Issues/Concerns:

_____

_____

__ _____

Medications:

_____

_____