Universal Referral Form

Date of Referral: _________________ Patient/Client is aware of Referral: YES NO

Patient/Client Name: _________________________ Patient/Client DOB: ______________

Current Contact Information of Client

Phone Number: _______________________ Alternate Phone Number: _______________

Address: ____

Insurance:

- Medicaid
- Medicare
- Private Insurance (please list): __________________
- None
- Unknown

Insurance Number (if known): _______________________

Physical Health/Mental Health/Substance Use Diagnoses (if known):

Reason for Referral (e.g. presumptive diagnosis, screening results, legal system requirements, etc.)

Referring Professional: _____________________________ Phone: _________________________
Organization: _____________________________________ Email: _________________________
Specialty: ____ Fax: ___________________________

Next Steps:

-Please fax (along with a signed release of information) to (719)-966-8108

-Call (970)-824-LIFE to confirm receipt of this referral.

-We will follow up with the client/patient and you within 3 business days.