Health ONE The Medical Center of Aurora
Behavioral Health Services

Referral for Outpatient Psychiatric Clinic

FAX COMPLETED FORM TO:

Outpatient Psychiatric Clinic
Attention: Melissa Lauzon, Program Manager
720 Potomac St. Aurora, CO 80011
Phone: 720-282-8015 | Fax: 303-340-9927

Date of Referral: _____
Contact Name: _____
Contact Phone: _____

Name: Date of Birth: Race/Ethnicity:

Gender: ❒Male ❒Female ❒Non-binary/third gender ❒ Prefer not to say

❒Prefer to self-describe_____

CONTACT NUMBERS: Ok to leave voicemail? ❒Yes ❒No
HOME:
CELL:

ADDRESS:

Service Requested:

☐ Partial Hospitalization Program - Half Day
Program hours 9:00am-3:00pm

❒ Intensive Outpatient Program
Program hours 9:00am-12:00pm or 12:00pm-3:00pm

Primary Diagnosis:

Health Issues or Other Concerns:

Prescribing Physician name & Phone (email optional):
_____

Reason for referral for treatment: In your own words, describe the adult in need for mental health services. Please describe specific behaviors the adult is exhibiting.

_____
_____
_____

Please attach the following:

☐ **Face sheet**
☐ **Current H&P &/or Psych Evaluation**
☐ **Signed Release of Information Form**
☐ **Current medication list**
☐ **Copy of insurance cards**
☐ **Applicable progress notes**

Referring Provider:

Name: _____
Phone: _____
Fax: _____
Email: _____

Updates Requested:

☐ Upon admission
☐ Discharge summary

By:
☐ Phone ☐ Fax ☐ Email