Health
SOLUTIONS WEST
Hope. Health. Together

Referral Fax Line: 970-683-7235
OR
Encrypted Email Address Only:
OutpatientReferrals@healthsolutionswest.org

If this is an emergency, please call the Colorado Mental Health Line at 988

Individual Information		
Name:	**Preferred Language if not English:**	
If minor, Parent or Guardian Name:		
Address:		
Phone:	**Cell:**	**Date of Birth:**
Referral Source Information		
Referring Agency:	**Date of Referral:**	
Your Name:		
Phone:	**Fax:**	**Release Signed? ☐ Yes ☐ No**
Why is the client being referred? ☐ Therapy ☐ Medication Management ☐ Diagnostic Clarification ☐ Unsure		
Behaviors/Concerns? ☐ **Psychosis** ☐ **Suicidality** ☐ **SUD** ☐ **Mood Disorder** ☐ **Medication Assisted Treatment** ☐ **Other**		
Other Relevant Information/Explanation:		
Does individual have: ☐ Medicaid Insurance ☐ Private Insurance Name:		
Please provide the most recent list of medications and any relevant notes or labs:		
If applicable, are records attached? ☐ Yes ☐ No		
INTERNAL USE ONLY **Referral Status**		
Date Referral received by HSW:	**HSW Initials:**	
Appointment Scheduled: ☐ Yes ☐ No	**Appointment Kept: ☐ Yes ☐ No**	
Outreach Attempt: **Date:** **Time:** ☐ **No Response** ☐ **Declined Referral**		