Health ONE Behavioral Health & Wellness Center
A Campus of The Medical Center of Aurora

Referral for Outpatient Behavioral Health Services

SEND COMPLETED FORM TO:

Outpatient Behavioral Health Services

By Fax: 303-945-7887
Phone: 303-360-3736

Preferred Location:

- ☐ Aurora (Medical Center of Aurora-North Campus)
- ☐ Denver (Rose Medical Center Campus)
- ☐ Centennial (Centennial Hospital Campus)
- ☐ Ken Caryl/Littleton (CareNow Littleton Campus)

Date of Referral: _____

Contact Name: _____

Contact Phone: _____

Email: _____

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:

☐ Adolescent – Partial Hospitalization Program
Program hours M-F: 9a-3p

☐ Adolescent - Intensive Outpatient Program
Program hours: Varies per location

❒ Adult - Partial Hospitalization Program
Program hours M-F: 9a-3p

❒ Adult - Intensive Outpatient Program
Program hours: Varies per location

Primary Diagnosis:

Health Issues or Other Concerns:

Prescribing Physician name & Phone (email optional):

_____

Reason for referral for treatment: In your own words, describe the individual in need for mental health services. Please describe specific behaviors they are 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