Date:

HeartCentered COUNSELING
A LIFESTANCE HEALTH COMPANY

Referral Form

Please email to referralcoord@heartcenteredcounselors.com,
fax to 888-965-4615, or call 970-632-1133.

Referring Provider Information

Clinic/Office Name:
Parent Organization:
Name of Referring Provider:
Office Address:

Email Address:
Phone Number:
Fax Number:

Patient/Client Information

Name:
DOB:
Insurance Provider:
Plan Name:

Phone Number:
Okay to Leave Message? Text?
Email Address:
Okay to Email?

Preferred Method of Contact (check all that apply) Call ☐ Text ☐ Email ☐

Reason for Referral Therapy ☑ Psychiatry ☐ Both ☐

TELE-INTEGRATED!

Current Medications, Substance Use History, Additional History (for psych referrals only)

Taking a controlled substance?

If yes, please list:

Ever seen a med provider at HCC before?

Ever dismissed from a mental health or substance abuse clinic?

Hx of substance abuse:

- Currently using substances?
- If no, how long since last use?

Hx with or current disordered eating?

Pregnant or planning to become pregnant?

Physical limitations that may make navigating stairs in our office a challenge?

Any other services required (e.g., disability or FMLA paperwork)?

Willing to see provider outside of home area?

Any other medical conditions our med provider should know about?