Peak View
BEHAVIORAL HEALTH

Fax Referral Form

Date:_____
Patient/name:_____
DOB:_____
Reason for assessment referral (check all that apply):

- 0 **Depression**
- 0 **Anxiety**
- 0 **Grief and Loss**
- 0 **Isolation**
- 0 **Withdrawal from normal activities**
- 0 **Relationship concerns**
- 0 **Sudden change in ADLs/ What level of assist if any is needed?_____**
- 0 **Change in mood/functioning level**
- 0 **Sudden onset of hallucinations, delusions or paranoia**
- 0 **Noncompliance with prescribed meds**

What outcome are you hoping for by referring your patient to us?:
_____

DME Equipment needed? _____

Request for Mobile Assessment? Y/N

Please provide:

-Face Sheet/Demographics
-Insurance info.
-Recent medication list
-Recent labs (last 30 days)
-Nurse/provider notes
Referring organization:_____
Person sending request:_____
Contact number:_____

Instructions:
Please fax this form with supporting documentation to our admissions team to Fax# : 719-355-1059
Hospital phone: 719-444-8484

We appreciate the opportunity to support you and your patients!!!