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: June 24, 2015
Contact Name: Gregory O'Connor
Contact Phone: 425-178-7316

Name: Jane Doe
Date of Birth: January 1, 1978
Race/Ethnicity: Non-Hispanic white

Gender: ☐ Male ☑ Female ☐ Non-binary/third gender ☐ Prefer not to say
☐ Prefer to self-describe_____

CONTACT NUMBERS: Ok to leave voicemail? ☑ Yes ☐ No
HOME: (313)313-3113
CELL: (608)921-1234

ADDRESS:
123 W Mifflin Ave Madison, WI 53709

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):
Andrew Robinson, 441-034-0750, andrew_r@gmail.com

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.
Family members describe recent confusion in time or place and struggling to articulate ideas in speaking or writing over the past three months.

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: Andrew Robinson
Phone: 441-034-0750
Fax: 615-917-4053
Email: andrew_r@gmail.com

Updates Requested:

☑ Upon admission
☐ Discharge summary

By:
☑ Phone ☐ Fax ☐ Email