ROCKY MOUNTAIN WELCOME CENTER

MENTAL HEALTH & WELLNESS REFERRAL FORM

Date of referral: _____

Client Full Name: _____

Date of Birth: _____ Gender: _____

Preferred Language: _____

Client Contact Information:

Phone #: _____ Email: _____

Preferred form of contact:

- ☐ Phone Call (with permission to leave a voicemail)
- ☐ Text message
- ☐ Email

Zip Code of Residence: _____

Funding Source for Services

- ☐ Medicaid; Medicaid ID (if applicable) _____
- ☐ Contracted Services with the referral source
- ☐ Self-pay by the client

Reason for referral (Check all that apply)

- ☐ Depression
- ☐ Anxiety
- ☐ Trauma / PTSD
- ☐ Substance Use concerns
- ☐ Psychosis / Hallucinations
- ☐ Suicidal / self-harm risk

- ☐ Behavioral Concerns
- ☐ Adjustment disorders
- ☐ Immigration related stress
- ☐ Domestic Violence Concerns
- ☐ Interpersonal conflict
- ☐ Limited life skills
- ☐ Other: _____

Current concerns and relevant background information (Brief description of symptoms, behaviors, or challenges client is experiencing):

_____

_____

_____

_____

Services requested (Check all that apply):

- ☐ Individual Therapy
- ☐ Couples Therapy
- ☐ Family Therapy
- ☐ Group Therapy
- ☐ Psychoeducational Groups

Referral Source Agency: _____

Person making the referral: _____

Your phone number: _____

Your email: _____

*Please ensure that the client you are referring is aware that someone from the Rocky Mountain Welcome Center will be reaching out to them about therapeutic services.

Any questions or concerns, please contact the Bilingual Clinical Director, Erin Twiehaus, LCSW at erin@rockymountainwelcome.org. Thank you for your collaboration!