THE COMPASSION COLLABORATIVE
COUNSELING ▪ EDUCATION ▪ ADVOCACY

Outpatient Referral Form

Thank you for your referral to The Compassion Collaborative!
Please submit this form via fax or email to refer patients for therapy.
Email: Intake@thecompassioncollaborative.com | Fax & Phone: 719-357-7504
Website: www.Thecompassioncollaborative.com

I: REFERRING ORGANIZATION/PROVIDER INFORMATION

Organization: Provider Name:
Office Phone #: Office Fax #:
Email: Office Contact Name:

II: PATIENT & FAMILY INFORMATION

Patient Legal Name: Preferred Name:
Date of Birth: Sex Assigned at Birth: Gender:
Phone: Email(s):

If Applicable:
Parent/Guardian Name: Guardian 2 Name:
Phone(s): Email(s):

III: CLINICAL INFORMATION

Requested Therapist **and/or** Specialty Area:
Scheduling Preferences (Days/Times):
Reason for Referral:

Preferred Location: (In Person in Colorado Springs OR Telehealth):

IV: INSURANCE INFORMATION

Accepted Insurances: Colorado Medicaid (Regions 3,5,6,& 7- Colorado Access, CHP+, CCHA), Cigna/Evernorth, Aetna. Some providers also accept UHC & Anthem/BCBS.

*Insurance Carrier and Member ID:

OR
Patient Elects to Pay Out of Pocket AND does not have Medicaid coverage:
Additional Information: