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: 719-434-9867 | Phone: 719-357-7504
Website: thecompassioncollaborative.com

I: REFERRING ORGANIZATION/PROVIDER INFORMATION

Organization: ______________________________ Office Phone #: __________________
Provider: _________________________________ Office Fax #: __________________
Email: ___________________________________ Office Contact: __________________

II: PATIENT & FAMILY INFORMATION

Patient Legal Name: ____________________ Preferred Name: ________________________
Date of Birth: ____________________ Phone: ____________________________________
Email(s): ____
Preferred Contact Method: Phone Email

Parent or Guardian Contact Information if Applicable

Parent/Guardian1 Name: ____
Parent/Guardian 2 Name: ____
Phone 1: _______________________ Email 1: __________________________________
Phone 2: _______________________ Email 2: __________________________________

III: CLINICAL INFORMATION

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

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

IV: INSURANCE INFORMATION

Accepted Insurances: Medicaid (All Regions), Cigna/Evernorth, Aetna, Kaiser/Carelon, Anthem BCBS,UHC, UMR, & Medicare.

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OR

Patient Elects to Pay Out of Pocket AND does not have Medicaid coverage: ______________

Additional Information: ____
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