FAX REFERRAL FORM TO:
307.632.3298 Wyoming
970.372.6412 Colorado

QUESTIONS?
Call 307.630.4729 WY, 970.888.4070 CO
or email info@livhealth.org

FIND OUR REFERRAL FORM ONLINE: LIVHEALTH.ORG/REFERRALS

WHAT SERVICE(S) ARE YOU INTERESTED IN?

☐ COUNSELING ☐ PSYCHIATRIC MEDICATION EVALUATION & TREATMENT ☐ CASE MANAGEMENT ☐ MEDICAL

MENTAL HEALTH URGENT CARE LOCATED AT 2500 DELL RANGE BLVD IN CHEYENNE
Open Mon-Fri 9a.m.-7p.m. | Sat-Sun 10a.m.-6p.m. | Walk-Ins welcome or visit us virtually at livhealth.org

Referring Agency/Provider: ______________________ Phone: ______________

Email: ______________________ Today's Date: ______________

Please include the following with the referral when available:

☐ Demographic Sheet ☐ History and Physical (H&P) ☐ Discharge Summary

Patient Information:

First Name: ______________ Last Name: ______________ Initial: ______

Address: ______________________ Phone: ______________

City: ______________ State: ________ Zip: ________ DOB: ________

Email Address: ______________________________

Primary Insurance: ______________ Secondary Insurance: ______________

Diagnosis:______________________________

Is patient currently receiving home care or other service? ☐ Yes ☐ No If yes, please explain

Number of people living in the home ________ ☐ Not Sure

Does the patient have any history of violence? ☐ Yes ☐ No If yes, please explain

Emergency Contact: ______________________ Phone: ______________

Next of Kin: ______________________ Phone: ______________

Additional Information: