Griffith Centers
Hope and Healing Starts Here

Referral for Outpatient Services

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Date of Referral:	
Referring Professional:	Agency:
Email Address:	Phone:

Case Name:	Trails ID:	HH #:
Client/Sponsor Child Name:		
Client Ethnicity:	Client Gender:	Client DOB:
Case Family Address:		
Case Family Phone:		
Is English the client/family primary language: ☐ Yes ☐ No – Primary Language is:_________		

Who holds therapeutic/medical decision making for the client? ☐ Self (15 years and older) ☐ Both parents ☐ *One parent* ☐ *DHS* ☐ *GAL* ☐ *Other:____________________*	**If anything other than Self or Both Parents (checked left) then supporting documentation is needed.*** (i.e. court ordered services or legal documentation) **Can you provide this documentation?** ☐ Yes ☐ No
Is there a Guardian Ad Litem (GAL) involved? ☐ Yes ☐ No **Does the GAL hold LAN?** ☐ Yes ☐ No	**If answered yes to the question on the left then please provide GAL information:** **Name(s):______________________________** **Phone #:______________________________** **E-mail: _______________________________**

Service Requested:

☐ Individual Therapy
☐ Family Therapy
☐ Family Preservation
☐ Play Therapy
☐ Mentor Services
☐ Specialized Services (EMDR, AF-CBT)
☐ Truancy Services (chronically absent)
☐ Behavior Coaching (skill based)
☐ Mental Health Needs Assessment
☐ Psychiatry Services (May have additional requirements)
☐ Substance Use Disorder Services (therapy/group/PHP)
☐ UA (Urine Analysis) services

Location Requested: (Choose column A and then column B)

Column A: (Choose 1)

☐ Buena Vista, CO
☐ Centennial, CO
☐ Colorado Springs, CO
☐ Grand Junction, CO
☐ Greeley, CO
☐ Denver, CO

Column B: (Choose 1 preferred)

☐ In-person- comfortable office environment
☐ In client's home
☐ In the community
☐ virtual
☐ other: ____

Send Completed Form to referrals@griffithcenters.org

Funder for Requested Services (must provide funder information for services requested):

- ☐ Medicaid (*Medicaid services are subject to approved authorization)*
- ☐ Colorado Access
- ☐ CHP PLUS/Colorado Access
- ☐ Community Health Alliance (CCHA)
- ☐ Northeastern Health Partners (NHP)
- ☐ Health Colorado
- ☐ Cigna
- ☐ Tricare
- ☐ BCBS (limited providers)
- ☐ CHP+ Rocky Mountain
- ☐ UHC
- ☐ Self-Pay (Colorado Springs location ONLY)
- ☐ Rocky Mountain Health Maintenance Organization (RMHN)

Medicaid #: __________________ Client DOB: ___________________

Additional Services

List additional services or additional involved agencies (*DHS, DYC, Probation, WRAP, Foster Care, Group Home etc*):

Family Structure

List all other case family members including parents, siblings, and/or significant others involved:

Name	Relationship to Client	Phone Number

Presenting Problem/Case Information

Please include information on any active restraining orders or safety concerns/risks:

Foster Parent/Kin Provider/Caregiver Information

List current guardian(s) for the child(ren), contact information, and address(es), if applicable:

**** Please Attach FSP/Social History if applicable****

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