Care Coordination Referral

Referring agency/provider/self: _____

Person referring: _____

Patient name: _____

Referral date: _____

Phone: _____

Patient phone: _____

Patient DOB: _____

Patient has consented to contact and exchange information with this person: ☐ yes ☐ no

Reason for referral (check all that apply)

- ☐ Complex medical and/or behavioral health condition
- ☐ Desire for Substance Abuse treatment
- ☐ Requires services of a doctor, dentist, behaviorist, or specialist
- ☐ Pregnancy/post-partum

Other notes or concerns: _____

For further questions or concerns about this client you can call or email our Recovery Nurse Advocate Team (Michelle Deuto, BSN, RN, RNC and Stacy Hernandez, BSN, RN) at Lutheran Medical Center.

Phone: 303-467-4008
Email: Peaks-RecoveryNurseAdvocateTeam@imail.org
Fax: 303-403-6274

West Pines
BEHAVIORAL HEALTH | SCL Health