CLEAR VIEW
BEHAVIORAL HEALTH

Date: _____

Patient/Resident Name: _____

DOB: _____

Voluntary or Involuntary (circle one)

Reason for assessment referral (check all that apply):

- **Depression**
- **Anxiety**
- **Grief and Loss**
- **Isolation**
- **Withdrawal from normal activities**
- **Relationship concerns**
- **Sudden change in ADLs**
- **Change in mood/functioning level (does not require acute hospitalization)**
- **Sudden onset of hallucinations, delusions, or paranoia**
- **Noncompliance with prescribed meds**
- **Potential danger to self or others (suicidal/homicidal ideations)**
- **Substance Abuse**
- **Other _____**

Comments:_____

_____

_____

Please Provide:

-Face Sheet **-Medication List**

-Recent Labs **-Nurse/Provider notes**

Referring location (physician signature NOT required): _____

Person sending request: _____

Contact number & email: _____

Please note: Labs may be required for medical clearance.

Fax: 970-461-3668

Hospital Phone: 970-461-5061