



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.

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Hospital Phone: 970-461-5061