Antelope Recovery
1035 Pearl St #313
Boulder, CO 80302-5130

REFERRAL FORM

Fax to: 303-622-5697
Email to: Referral@AntelopeRecovery.com

Client Name: _____ DOB: _____
Primary Caregiver Name/relationship: _____
Insurance Provider: _____
Best way for Antelope to contact: _____

Presenting Concerns

Reason for referral (check all that apply):

☐ Anxiety ☐ Depression ☐ Behavioral concerns ☐ Substance use

☐ School issues/attendance ☐ Family conflict ☐ Peer conflict

☐ Emotional regulation ☐ Legal involvement ☐ Other: _____

Brief summary of current concerns:

_____

_____

Previous Treatment (include dates, if applicable)

☐ Inpatient psychiatric treatment ☐ Intensive outpatient treatment ☐ Outpatient therapy

☐ Substance use treatment ☐ Medication management ☐ None ☐ Other: _____

Current Providers

Is the youth currently working with another therapist or behavioral health provider?

☐ No ☐ Yes → If yes, who/for what: _____

Safety History

History of:

Suicide attempts: ☐ Yes ☐ No ☐ Current thoughts/ideation

Self-harm behaviors: ☐ Yes ☐ No ☐ Current behaviors

Harm toward others: ☐ Yes ☐ No ☐ Current thoughts/behaviors

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Substance misuse: ☐ Yes ☐ No ☐ Current use/concerns

System Involvement

Is the youth currently involved with any of the following?

☐ Court / Probation ☐ Diversion program ☐ Child Protective Services (DHS / CPS)

☐ School disciplinary process ☐ None ☐ Unsure

Details (if applicable):

_____

Court Requirements (if applicable)

Is treatment court-mandated? ☐ Yes ☐ No

If yes, please describe requirements:

_____

_____

Telehealth Access

Does the youth have reliable internet access and a device for telehealth? ☐ Yes ☐ No ☐ Unsure

Parental Involvement

Will the youth be participating in treatment independently (without caregiver involvement)?

☐ Yes ☐ No ☐ Unsure

Additional Comments

_____

_____

Referring Provider Name: _____

Date: _____