County of Colusa
Department of Behavioral Health

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Emergency Department Referral for Mental Health and/or Substance Use Follow up

Instructions: *Please complete the fields below to submit a referral or follow-up request for a patient that presented to your facility and was determined to be experiencing a mental health or substance use condition. Once completed, email securely to: colusabhs@countyofcolusa.org or Fax to: 1.530.458.7751 Attn: ACCESS Team*

Is the patient a Colusa County Resident? ☐ Yes ☐ No If No, **STOP** do not complete this form; refer patient to their county of residence

Does the patient have Medi-Cal? ☐ Yes ☐ No If No, **STOP** do not complete this form; refer patient to their insurance provider

Program referring to: ☐ Mental Health (MH) ☐ Substance Use (SUD)

Date(s) of Service at ED/ER:_____Discharge Date from ED/ER:_____

Reason for Referral/Suspected MH/SUD Diagnosis:_____

Referring Hospital:_____Contact Person:_____

Hospital Address:_____Phone#:_____

Patient Name:_____Date of Birth:_____

Patient Mailing Address: _____

Patient phone#_____Patient Preferred Language:_____

Parent or Guardian name if patient is a minor or conserved adult:_____

Parent/Guardian phone #: _____

Comments or other helpful information (Optional):_____

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