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*

1. Is the patient a Colusa County Resident? ☐ Yes
   ☐ No – **STOP** do not complete this form; refer patient to their county of residence
2. Does the patient have Medi-Cal? ☐ Yes – ID #:_____
   ☐ No – **STOP** do not complete this form; refer patient to their county of residence
3. Program referring to: ☐ Mental Health (MH) and/or ☐ Substance Use (SUD)

Patient Name: _____ Date of Birth: _____

Patient Mailing Address:_____

Patient phone #:_____ Preferred Language: _____

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

Parent/Guardian phone #_____

Enrollment date of service at ED/ER: _____Discharge date from ED/ER:_____

Service Code for ED Visit: _____

Principle Diagnosis Code of ED Visit:_____

Referring Hospital:_____ Contact Person: _____

Hospital Address:_____ Phone#: _____

Comments or other helpful information (Optional):_____

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