Referral Form

Western Slope Psychological Services, Pllc

Patient Name:	Date:
Date of Birth:	Referring Provider:
Insurance:	Phone:
ID Number:	Fax:
Group Number:	Point of contact regarding referral: (Name/Ph #)
Dx Codes:	Provider Signature:

Referral Fax: **970-609-0928** Phone: 970-275-2778 Email: **drdanraker@gmail.com**

PLEASE INCLUDE THE FOLLOWING FOR PROMPT PROCESSING:

- ❑ Patient Demographics
- ❑ Insurance Information w/ copy of card
- ❑ Most Recent Chart Notes (w/referral information details)
- ❑ Any Behavioral Health Test Results (BBHI, PHQ, BDI, etc.)

- ❑ Referral to **Evaluate Patient Fitness for Device/Procedure**:
  - ❑ Spinal Cord Stimulator (SCS) ❑ Peripheral Nerve Stimulator
  - ❑ Intrathecal/Pain Pump ❑ Intervertebral Spacer ❑ INTRACEPT
  - ❑ Other: _____
- ❑ Referral for **Opioid Risk Evaluation**
- ❑ Referral for **Treatment Interference Consultation**:
  - ❑ Communication Issue ❑ Behavioral Issue
  - ❑ Emotional Activation ❑ Pain Management Skills
  - ❑ Brief Therapeutic Support: _____
  - ❑ Other issue: _____
- ❑ Other Referral Request:

  _____

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