Email: Referral@ElPasoCares.org
El Paso Office: (602) 388-4017
Fax: (833) 518-1261

Referral Form

Today's Date: | Time:

Information for Person Being Referred					
Name:				D.O.B	
Address/City/Zip Code:					
AHCCCS ID #:			Insurance Group Provider:		
Primary Language:					
If Minor, what is Parent/Guardian's Name					
Contact Information	Mobile #:			Home #:	

Check One or Both			
Telehealth		In Home	

Mark box that applies to Person Being Referred			
Individualized Intensive Outpatient (I-IOP)		Program for Ongoing Health Concern	
Behavioral Coaching		Crisis Hospitalization Follow-up Program	
Equine Assisted Group for Children		Mentoring:	
Chronic Pain Program		Counseling:	
Adult Group-home Placement Preservation		Other:	

Please Descibe Initial Concerns:

Information for Referral Source				
Name of the Agency:				
Person to Contact:				
Contact Information	Your mobile #:		Work #:	
Name of PCP:			Office Phone:	

Send To: Referral@ElPasoCares.org

OFFICE USE ONLY						
Date Referrel received						
1st contact attempt	Date/Time		Result			
2nd contact attempt	Date/Time		Result			
3rd contact attempt	Date/Time		Result			
Consent from referral agency received					Yes	No
If yes, was referral agency contacted?					Yes	No