CONFIDENTIAL

ACCESS PROGRAM
1-800-491-9099

Primary Care Referrals for Specialty Mental Health Services

Facsimile Transmittal Sheet

Date: _____

To: **ACCESS**

Fax #: **510-346-1083**

From: _____

Fax #: _____

Phone #: _____

Client Name: _____ **Date of Birth** _____

Parent/Guardian Name (if applicable): _____

Additional Information: _____

_____

_____

[ ] I have discussed this referral with my patient/client and directed him/her to call ACCESS next day to complete referral. **Completed Screening Form is attached.**

ACCESS to Complete:

[ ] CLIENT HAS NOT CONTACTED ACCESS TO COMPLETE THE REFERRAL PROCESS

REFERRED TO:

Provider Name or Managed Care Plan: _____

Phone#: _____ Fax #: _____

Provider Name: _____

Phone#: _____ Fax #: _____