

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: (3 Lines Max)

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 #: \_\_\_\_\_

**ACCESS unable to forward your contact information. Please reach out to provider(s).**

The information contained in this fax is confidential under the California Penal Code. It is intended *only* for the use of the individual to whom it is addressed. If you are not the intended recipient, or the employee or agent responsible for delivery to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this fax in error, please immediately notify the sender by telephone.