Family Care Center
Behavioral Health Services

PROVIDER REFERRAL FORM

Please fill out the information below and fax this form to 719.623.0165.

Referring Provider:	
Provider Email:	Date:
Clinic Name:	Clinic Location:
Clinic Phone Number:	Fax Number:

Patient Name:		Date of Birth:
Street Address:		
City:	State:	Zip Code:
Phone Number:	Insurance Carrier:	

Is the patient an Active-Duty Service Member? Y: ☐ N: ☐ Unsure: ☐

Which services would you like your patient to receive?

Therapy: ☐ Medication Management: ☐ Transcranial Magnetic Stimulation (TMS): ☐

If checked "YES" for TMS Services:

Has the patient been on at least 2 antidepressant meds? Y: ☐ N: ☐ Unsure: ☐

Has the patient been involved with talk therapy? Y: ☐ N: ☐ Unsure: ☐

fccwellbeing.com

Phone: 888.374.5066

Fax: 719.623.0165

Email: referrals@fccsprings.com

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