

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

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