**Care Coordination Referral Form**

\*Please transmit this form via secured email or via fax to Sanilac County Community Mental Health Authority at XXXXXXXX@sanilaccmh.org or 810-648-0319. Form must be signed by the individual being referred or their guardian.

Referring Practitioner or Facility Name:

Phone:       Fax:       Email:

Name of contact person:

Individual’s Name:       DOB:

Phone:       Address:

Diagnosis:

Please provide a brief description of why the individual is being referred:

Additional information for our team:

I,       (name of individual), do understand that this referral to Sanilac County Community Mental Health Authority is voluntary and that by signing I give my consent to be contacted by Sanilac County Community Mental Health Authority to set up an appointment.

Signature:       Date:

Policy Committee – 12/12/2024 Form #0587