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Phone: (720) 248-7318  
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[contact@mosaictherapyco.com](mailto:contact@mosaictherapyco.com)  
[www.mosaictherapyco.com](http://www.mosaictherapyco.com)

**Portal access for new or existing clients:**  
<https://mosaictherapycollective.clientsecure.me/>

## Mosaic Therapy Collective Referral Form

### Referral From:

- Name of Provider or Agency: \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Fax Number: \_\_\_\_\_
- Email Address: \_\_\_\_\_

### Referring To:

- Name of Provider (if applicable): \_\_\_\_\_ Or Mosaic Therapy Collective
- Phone Number: (720) 248-7318
- Fax Number: (720) 806-5612
- Email Address: [contact@mosaictherapyco.com](mailto:contact@mosaictherapyco.com)

### Client Information

- Client Name: \_\_\_\_\_
- Date of Birth: \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Email Address: \_\_\_\_\_
- Address: \_\_\_\_\_
- Insurance Carrier: \_\_\_\_\_
- Insurance Member ID#: \_\_\_\_\_
- Insurance Group # (if applicable): \_\_\_\_\_

### Reason for Referral

(Select all that apply)

- ☐ Anxiety
- ☐ Depression
- ☐ Trauma/PTSD
- ☐ Life Transitions



- ☐ Relationship Concerns
- ☐ Identity Exploration (e.g., LGBTQ+, cultural, racial)
- ☐ Body Image/Eating Disorders
- ☐ ADHD/Autism Spectrum/Neurodiversity
- ☐ Eating Disorder/Disordered eating/Dieting/Body image
- ☐ Grief/Loss
- ☐ Other or provide additional information:

☐ \_\_\_\_\_

☐ \_\_\_\_\_

### Preferred Services

(Select any applicable services you would like the client to explore.)

- ☐ Individual or Couples/Marriage Therapy (Virtual or In-Person in Broomfield, CO)
- ☐ Walk and Talk Therapy (Location varies)
- ☐ Yoga, Somatic, or Mindfulness-Based Therapy
- ☐ Eye Movement Desensitization and Reprocessing (EMDR) Therapy and/or Intensive EMDR Therapy
- ☐ Group Therapy
- ☐ Other: \_\_\_\_\_

### Authorization to Release Information

By signing below, I authorize [Provider/Practice Name]\_\_\_\_\_ to release relevant information about my care to Mosaic Therapy Collective for the purpose of this referral.

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Parent/Guardian Signature (if applicable):** \_\_\_\_\_

**Date:** \_\_\_\_\_

### Fax or Email Completed Form To:

- Email: [contact@mosaictherapyco.com](mailto:contact@mosaictherapyco.com)
- Fax: 720-806-5612

For questions or assistance, please call or text us at 720-248-7318 or [contact@mosaictherapyco.com](mailto:contact@mosaictherapyco.com).