

REFERRAL FORM

Date: _____

Referring Doctor's Information	Referring to (Doctor, Clinic):
Name _____	Name _____
Address _____	Address _____
_____	_____
City, State, Zipcode _____	City, State, Zipcode _____
Phone(s) _____	Phone(s) _____
Fax _____ Email _____	Fax _____ Email _____

Patient Information

First Name _____ Last Name _____

Address _____

Phone Number _____ Ok to leave voice messages at this number? () Y () N

Best days/times to be reach the patient: _____

Insurance provider(s) _____

Is substance abuse treatment covered? ____ Yes ____ No/Unknown

Reason for referral _____

Opiate and other substance history (include current and past addiction/abuse of alcohol, prescription drugs, and illegal drugs; treatment history): _____

Medications: _____

PLEASE CONTINUE ON NEXT PAGE

REFERRAL FORM (PAGE 2 OF 2)

Patient Name _____

Date _____

Test results and dates: (Hepatitis C, liver enzymes, urine test) _____

Other Medical History (include psychiatric diagnosis if any): _____

Referring Doctor Signature

Patient Signature