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):____

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____

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)______________________________________

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

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__________________________________ Referring Doctor Signature

_____________________________________ Patient Signature