***Substance Abuse Patient Referral Form***

**Demographic Information**

First Name:       Last Name:       DOB:

Street Address:

City:       State:       Zip Code:

Phone:        Secondary Phone: :

SS#:       Gender: [ ]  Male [ ]  Female Pregnant?

**Substance Abuse Information**

What is patient using?

Is patient currently in withdrawal?

Has client been treated for an overdose?  If Yes, When:

Is client an IV drug user?

**Insurance Information**

Type of Insurance [ ]  Private Insurance [ ]  Medical Assistance [ ]  None

ID#       Group#

Phone Number for Behavioral Health Coverage:

Subscriber Name:       Subscriber DOB:

**Referring Entity**

Name:       Phone Number:

Agency Name:       Contact Email:

ADDITIONAL INFORMATION (If necessary):

 ……………………….……FOR INTERNAL USE ONLY…………………………..………

Date Referral Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Received By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Referred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Verified by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_