Substance Use Treatment Referral Form

Patient Name:_____

Patient Phone #:_____

Date of Birth:_____ Sex:_____

REFERRAL FROM: _____
(practice or provider name)

Address: _____

Phone #: _____ Date of Referral: _____

REFERRAL TO: _____
(if unknown at this time, put type of facility or organization)

Address: _____

Phone #: _____

Reason for Referral:

Treatment or Other Services Requested: (check all that apply)

- ☐ Outpatient Counseling
- ☐ Medication-Assisted Treatment (Suboxone or methadone)
- ☐ Needle or Syringe Exchange Program
- ☐ Other: _____
- ☐ Health Education
- ☐ Primary Care Services
- ☐ Case Management
- ☐ Peer Support Groups (NA/AA)

Medical Conditions: (list additional medical conditions here)

Insurance Carrier:_____

Insurance ID #: _____

REQUESTING PROVIDER NAME:_____

REQUESTING PROVIDER SIGNATURE:_____