



Appointment Services: 712 Jamestown Road
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REFERRAL FORM – OUTPATIENT SERVICES

Please check which services are needed:

- ☐ Mental Health
- ☐ Substance Use Disorder/ MAT
- ☐ IOP
- ☐ DWI
- ☐ Parenting Classes
- ☐ Domestic Violence/Anger Management
- ☐ CCA/Drug Assessment

****CASE PLAN IS REQUIRED FOR ALL DSS**

REFERRALS **

-Please send Case Plan with this referral form.

REFERRING PROFESSIONAL:

Provider Name/Facility: _____

Telephone: _____

Fax: _____

Referral Date: _____ (dd/mm/yyyy)

CLIENT INFORMATION:

Client Name: _____
Last Name First Name Middle Initial

Date of Birth _____ ☐ Female ☐ Male

Client Address: _____ City: _____

State _____ ZIP Code _____

Contact #: _____

Insurance: _____ Policy #: _____

*Attach demo and front/back of card. *DWI ONLY—Insurance does NOT cover Services**

PRIMARY CARE PHYSICIAN:

- ☐ Yes, If yes please explain: _____
- ☐ No

COMMUNITY AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency(s) (i.e. Child Protection, Community)

Professional (i.e. OT, Psychologist)

1. _____ . _____

2. _____ . _____

MEDICAL INFORMATION:

Primary Diagnosis:

Reason for Referral/Concern:

Included Attachments:

- ☐ Med History/ Case Plan
- ☐ Medication list
- ☐ Labs (i.e. Drug Screens, bloodwork)
- ☐ **DWI ONLY- BAC/ CITATION**

CCA needed? ☐ Update CCA
☐ New CCA

Date of recent CCA: _____