



Referral Form

Please share with us the following information:

Referred By: _____
Date given: _____

Name: (First, Last, MI) _____ DOB: _____

Are they known by any other name (Alias or Maiden Name): _____

Gender: Male _____ Female _____ Social Security #: _____

Marital Status: Never Married _____ Married _____ Widowed _____ Separated _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Email Address: _____

Are there any special calling instructions? _____

What is their form of payment? (Insurance, Medicaid, Self-Pay): _____

Insurance number (if available): _____

****PLEASE TELL THEM TO BRING IN THEIR INSURANCE CARD, MEDICAID CARD OR MEDICAID PENDING LETTER OR IF THEY DO NOT HAVE INSURANCE AND NEED TO BE ON A SELF-PAY SLIDING FEE, TO BRING IN PROOF OF THEIR INCOME (PAY STUBS, W-2,) AND BE PREPARED TO PAY TOWARD A FEE.**

****PLEASE NOTE THAT WE WILL BE UNABLE TO SEE ANYONE WHO DOES NOT HAVE SOME FORM OF PAYMENT OR IS NOT AT LEAST MEDICAID PENDING WITH THEIR PENDING LETTER**

Why are you referring them? _____

What substances (Alcohol, Drugs, and Prescriptions) are they using/abusing? _____

Are they reporting any mental health symptoms and are they taking any medications that you are aware of? _____

Are they receiving services from any other provider? _____

****If you do not have all of the information, please indicate "unknown" and fax it to 315-478-2510. Thank-You!**