MILESTONES DRP

REFERRAL

Today's Date: ________

Name: (Last, First, MI) ____ **Date of Birth**: ____/___/____.

Are you known by any other name (Alias/Maiden Name)? ____________________________

Gender: ◯ Male ◯ Female **Ethnicity**: ______________ **Social Security #**: _______-_______-_________.

Marital Status (*check one*): ◯ **Single** ◯ **Married** ◯ **Widowed** ◯ **Separated** ◯ **Divorced**

Address: ____ **Ok to send mail**? ___________

City: ____________________________ Zip Code ____________

Home Phone #: _____________ **Work Phone #**: _____________ **Cell Phone #**: _______________

Health Insurance Provider: ____

Member/ID/CIN #: ___________________________________

Emergency Contact Name: ____

Emergency Contact Address: ____

City: ____________________________ Zip Code: _____________________

Emergency Contact Phone: ____

What is thier relationship to this person? ____

What substances (Alcohol, Drugs, or Prescriptions) are they using/abusing? And last date of use reported?

____

____

Does this individual have a Mental Health Diagnosis? ____

____

Are they currently receiving services from any other provider, such as; *Primary Care, CHBS, Mental Health Connections, Insight House, ECT*. **PLEASE INCLUDE NAME AND DATES.**

1. ______________________________ 2. ___________________________________

3.________________________________ 4.___________________________________

**** (FOR MEDICATED ASSISTED TREATMENT ONLY): If Individual was on, Suboxone, Revia, Camprol, ect:, at your facility what was the dose prescribed?** ____

Please allow for a two week bridge script.

Any Additional Information that may be helpful to the clinician and Treatment Team while assessing this individual:____

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Contact Information for Person Completing Referral:

Name:____Title:___________________________

Organization:____

Address:____

Phone/Fax:_____________________________**Email**:___________________________________

PLEASE FAX THIS REFERRAL TO 315-507-5802.