Referral Form

*Please complete this form, attach additional clinical information as needed, and **fax to 503.535.7370**.*

Referring Professional Information

Time_____ **Date**_____/_____/_____

Referring Professional _____ **Agency** _____**City** _____ **State**_____

Work Phone_____ **Cell Phone** _____**Fax #**_____ **Pager** _____

Patient Information

Patient Last Name _____ **Patient First Name**_____ **Patient (Middle,Sfx).** _____

Patient Birth Date_____ **Age**_____ **SSN #.** _____ **Sex** _____**Marital Status**_____

Patient Address _____

Patient City/St/Zip _____ **Cell/Home Phone** _____ **Work Phone**_____

Family/Guardian Full Name _____**ROI** ☐ **Y** ☐ **N Cell/Home Phone** _____**Work Phone**_____

Who should we contact for initial outreach regarding this referral?

☐ Referring Professional ☐ Patient ☐ Family/Guardian

Level of Care & Treatment Program Recommendation

☐ Inpatient Hospitalization
☐ Partial Hospitalization/ Day Treatment
☐ Intensive Outpatient Program
☐ Unsure
☐ Mental Health
☐ Detox
☐ Co-occurring MH/SA
☐ Women's Program
☐ Behavioral Pain Management Program
☐ Impaired Professionals Program (IOP Only)
☐ Military Program

Presenting Problem _____

_____

_____

_____

_____

Diagnosis _____

Please attach any additional clinical information as needed

PRIMARYINSURANCE

Carrier _____

Subscriber Name _____**SS#**_____

Policy Number _____

Group Name _____ **Group No.** _____

Employer _____ **Phone #** _____

SECONDARYINSURANCE

Carrier _____

Subscriber Name _____**SS#**_____

Policy Number _____

Group Name _____ **Group No.** _____

Employer _____ **Phone #** _____