Substance Abuse Cohort Referral Form

Patient Demographics

PATIENT'S FIRST NAME	MIDDLE NAME	LAST	DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP CODE

COUNTY OF RESIDENCE	SSN#	MOBILE PHONE #	HOME PHONE #	MARITAL STATUS	SEX
EMAIL ADDRESS			PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other _____		

Guarantor Information

GUARANTOR NAME (FIRST,LAST)	RELATIONSHIP	PHONE
ADDRESS	CITY	STATE

Insurance Information

INSURANCE PROVIDER	SUBSCRIBER	RELATION TO PATIENT
SUBSCRIBER ID	GROUP #	STATE

History & Social

REASON FOR VISIT	REPORTED SUBSTANCES TODAY	SUBSTANCE USE HISTORY
PREVIOUS ER VISITS FOR SUBSTANCE ABUSE	HOW DID PATIENT ARRIVE AT ER	DOES PATIENT HAVE RELIABLE TRANSPORTATION?
DOES PATIENT HAVE FAMILY SUPPORT? IF SO, PLEASE LIST NAMES, CONTACT INFO:	ANY ADDITIONAL INFO TO ASSIST THIS PERSON IN SUBSTANCE TREATMENT?	

Substance Abuse Priority List

Please check one of the following priorities:

- ☐ Priority 1: Pregnant Female IV User
- ☐ Priority 2: Pregnant Female
- ☐ Priority 3: IV Drug User
- ☐ Priority 4: Female with Dependent(s)
- ☐ Priority 5: HIV Positive
- ☐ Priority 6: All Other Individuals

Note: Please fax any pertinent labs with this referral form.

Submitted By: _____