Fresh Start Detox & Sobering
ADDICTIONS RECOVERY CENTER

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www.addictionsrecovery.com

REFERRAL REQUEST FORM

Today's Date:	**Faxes sent after 4:00 P.M. will be processed on the next business day.**

Patient Information

Name:	Date of Birth:
Address:	Phone:

Does patient have insurance? ☐ Y ☐ N	Insurance Provider Name/Phone:

Primary Substance of Use: ☐ Alcohol ☐ Cannabis ☐ Amphetamines ☐ Cocaine ☐ Hallucinogens ☐ Opiates ☐ Sedatives/Stimulants ☐ Other _____	Usage Frequency, Amount & Route:	Last Date of Use:

Does the patient have a chronic medical condition? ☐ Y ☐ N	Chronic Medical Conditions & Level of Care:
Does the patient have a mental health diagnosis? ☐ Y ☐ N	Mental Health Conditions:
Is the patient currently taking medications? ☐ Y ☐ N	Patient Medications:

Can the patient perform their own ADLs? ☐ Y ☐ N	Is the patient pregnant? ☐ Y ☐ N If yes, expected due date:

Referring Agency Information

Attach Release of Information (ROI) for notification of patient admission status

Contact Initiated By: ☐ Patient ☐ Family ☐ Care Provider/CCO ☐ Other:

Name of Referring Agency:

Agency Contact:	Phone: