**Substance Use Treatment - Referral Form**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please fill in fields below and attach a completed Release of Information and current list of medications (if applicable). Please fax referral information to Peggie Ashlevitz at 708-597-8053.

**Referral Information:**

|  |  |
| --- | --- |
| Name: | Preferred Name (with title, if appropriate): |
| Address: | **Preferred Method of Contact:** |
| List insurance plan and RIN #: | **List insurance plan and RIN #:** |
| Diagnosis (If Available): | **Social Security Number:** |
| D.O.B.: | **Specialized Intake Needs:** |
| Reason(s) for referral: | **Additional Comments:** |

**Staff Information:**

|  |  |
| --- | --- |
| Name: | Company/Agency: |
| Position/Title: | **Program/Department:** |
| Phone #: | **Address of Company/Agency:** |
| Email: |  |

If you have any questions, please feel free to contact us by calling 1-888-828-5709.