

Fax: (513) 204-3476
for more information contact (513) 536-4673

Date of Referral:			
Patient Name:		Patient Phone Number:	
Referring Practitioner:		Referrer Phone Number:	
Reason for Referral:			
Payer Source:			
Benefits have been checked for Addictions IOP?		Yes <input type="checkbox"/>	No <input type="checkbox"/> Unknown <input type="checkbox"/>
Assessment for Addictions IOP needed?		Yes <input type="checkbox"/>	No <input type="checkbox"/> Unknown <input type="checkbox"/>
Is patient in need of detoxification?		Yes <input type="checkbox"/>	No <input type="checkbox"/> Unknown <input type="checkbox"/>
Is patient able to participate in a group format?		Yes <input type="checkbox"/>	No <input type="checkbox"/> Unknown <input type="checkbox"/>
Is patient clinically appropriate?		Yes <input type="checkbox"/>	No <input type="checkbox"/> Unknown <input type="checkbox"/>
Diagnosis (axis I and II):		Date of Diagnosis	
Substance History	Amounts	Frequency	Last Use
Alcohol			
Marijuana			
Opiates			
Benzodiazepines			
Stimulants			
Other (specify):			