LINK HOUSE INC.
PROVIDING THE TOOLS TO MAINTAIN LONG-TERM RECOVERY

CENTER FOR BEHAVIORAL HEALTH & ADDICTION TREATMENT SERVICES

Outpatient Referral Form

Client Name: _____ Date of Birth:_____

Address: _____Phone: _____

Email: _____ SS #: _____

Referred by: _____Internal Referral ☐ / External Referral ☐

Email: _____ Phone: _____

Address/Agency: _____

Referral date: _____

Reason for Referral: ☐ Therapy ☐ Med Eval ☐ Psych Eval ☐ SUD

Please Explain:

_____

_____

_____

Is client on any medications? ☐ Yes ☐ No

If so, please list_____

_____

_____

INSURANCE/MEDICAL INFORMATION:

Insurance Name: _____ Policy #: _____ Social Security #_____

Subscriber Name: _____ Subscriber DOB: _____ Relationship to Client: _____

Other insurance Name: : _____ Policy #: _____

Name of PCP: _____ PCP Phone #: _____ PCP Fax #: _____

Physician's Address: _____

Allergies: _____

Name of Psychiatrist: _____Psych Phone: _____ Psych Fax #: _____

EMAIL to: CBHATS@linkhouseinc.org

FAX to: 978-462-0735