



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 Eval MAT

Please Explain:

Is client on any medications? Yes No

If YES, please list including dosage:

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: _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

EMAIL to: CBHATS@linkhouseinc.org

FAX to: 978-462-0735