Referral Form

Thank you for your referral. Our facility will contact the client to schedule an appointment. Please discuss the nature and intent of this referral using this form.

Referral Source Information:

Referring Individual: _____

Referring Agency: _____

Agency Address: _____

Phone Number: _____ **Fax Number:** _____

Email Address: _____

Client Demographic Information

Client Name: _____

Date of Birth: _____ **Phone Number:** _____

Client Address: _____

Email Address: _____

Primary Insurance Carrier:

☐ *BCBS* ☐ *Cigna* ☐ *Aetna* ☐ *Hopkins EHP (IOP only)* ☐ *Medicaid*

Member ID #: _____

Please send this referral form to Program Director Marie Collins, LCPC at mcollins@resourcegrp.org, or fax it to 410-337-8729. For phone inquiries or to talk with our admissions team, call 410-337-7772 Option 3.

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Treatment Information

Primary Presenting Problem/Concern:

Substances being used (include frequency, amount used, and last date of use):

Does the client have any mental health diagnoses? ☐ YES ☐ NO

What current addiction and/or mental health services is the client receiving (indicate diagnoses, if applicable)?

Is the client currently prescribed any medications? Please list them.

Which SUD level of care is the client interested in / being referred to?

☐ Level II.1 IOP ☐ Level I OP ☐ Level 0.5 Early Intervention ☐ Evaluation Only

Please check off any mental health services the client is being referred for:

☐ Individual therapy ☐ Medication Management ☐ Dialectical Behavior Therapy (DBT)

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