Referral Form

Date of Referral _____

Please Include the Following Requirements:
1. Referral Page
2. Substance Abuse Assessment – Most Recent
3. Contact Phone Number
4. Current Valid Driver's License/State ID – Send Copy

305 N. 9th St. Norfolk, Ne 68701 Phone 402-999-4771 Fax: 402-370-9810

Full Name: _____ _____ _____
Last *First* *M.I.* *Age* *Date of Birth*

Address: _____
Street Address *(Current Placement)* *Apartment/Unit #*

_____
City *State* *ZIP Code* *Phone*

County of Legal Residence:_____ Social Security No.:_____ Marital Status:_____

Race:_____ Hispanic: YES ☐ NO ☐ Veteran: YES ☐ NO ☐ # of Dependents:_____

Education Level:_____ Annual Gross Income:_____ Income Source:_____

SSI/SSDI Eligible: YES ☐ NO ☐ Insurance: YES ☐ NO ☐ EPC or MHB: YES ☐ NO ☐ Suicide Attempts in Last 30 Days: YES ☐ NO ☐

Prior to Treatment Living Arrangements: ALONE ☐ W/RELATIVES ☐ W/NON-RELATED ☐ Type of Residence:___

Legal Status:_____ # of Arrests in Last 6 Months:_____ IV Drug User: YES ☐ NO ☐

Mental Health Diagnosis (Specify): _____

Medications:_____

_____

Dr.'s Appointment or Refill Instructions: _____

	1st Drug of Choice		2nd Drug of Choice		3rd Drug of Choice	
Name of Drug						
Age of 1st Use/Date Last Use						
Use in Past Month/How Often?	YES ☐ NO ☐		YES ☐ NO ☐		YES ☐ NO ☐	
Volume/Per Day, Week, or Month						
Route (Oral/Nasal/Smoke/IV)						

# of Prior Treatment Episodes:_____ Admission Date:_____ Expected Discharge Date:_____

Referred By for Dual Disorder Level of Care: (Counselor):_____ Counselor Signature: _____

Referral Taken By:_____