Patient Referral Form

Date of referral: _____

Please scan referral form along with all requested documentation to referrals@gatewaysrecovery.com to expedite intake for the patient. Referral will be contacted and provided with an intake appointment within 3 days.

Name: _____ DOB: _____

Address: _____

Phone: _____ Email: _____

Referral Source: _____ Contact Number: _____

Insurance Provider (please attach copy):_____

Did referral receive an Assessment: ☐ Yes (please attach) ☐ No

Does referral have Discharge Paperwork: ☐ Yes (please attach) ☐ No

Does referral have Laboratory Results (liver panel, toxicology): ☐ Yes (please attach) ☐ No

Is there a preference of date/time for appointment (if yes please list): _____

Additional comments / AOD History / Obstacles to treatment: _____

_____

_____

_____

_____

Referral to:

☐ Outpatient Counseling

☐ Intensive Outpatient Program

☐ Medically Assisted Treatment Program (MAT includes Outpatient Programs)

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