OUT FOR GOOD, INC.

Referral Form

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Referring Agency/Office / Clinic Information

Name of referring Agency**:** Todays Date**:**

Agency/facility fax number _____Phone contact number_____

Name of person completing form: Agency/facility address:

Referred Client/Patient Information

First name**:** Last name**:** DOB**:** Age:

Home address: City: Zip code:

Cell phone number: Home phone number_____

Ethnicity/Race: Email address:

Mass Health Insurance ID # Name of Insurance:

- □ Aetna
- □ Commonwealth Care
- □ **Blue Cross Blue Shield**
- □ Harvard Pilgrim
- □ Tufts Network
- □ EAP
- □ MassHealth
- □ MBHP

Reason for Referral:

_____

Primary mental health diagnosis/challenges:

Medical issues (if applicable) Yes or No (if yes, explain)

Drug of Choice:

History of SI/HI Yes or **No** (if yes, explain) _____ Court Involved: Yes or **No** Other agency involvement: Yes or **No**

Has the client ever tried to quit using a substance? YES NO If yes, what substance:

Does the client smoke cigarettes? YES NO

Does the client drink alcohol? YES NO

Is the client active in his/her addiction? YES NO If yes, what substance: _____