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Substance Abuse Treatment

Date of Referral _______ Initial Appt.date/time______________ReferralSource___________________

Treatment requested (please check):

SA OP________ MAT______________Group___________

First:	**Last:**	**M:**
DOB	**SSN:**	**Gender:**
Ins/MC	**Ins/MC#**	**Self Pay ____Y ____N**
Place of Employment:		**Job Title:**
DX Code:	**Ph#s**	**Waitlist: _____Y _____N**
Please check: _____married _____ Single _____ Separated _____ Widow _____Divorced _____ Cohabitating		

Current Residence:

Street:			
Town:	**State: ME**	**Zip:**	**Leave message?__Y___N**

History	YES	NO	Detail
Previous Treatment			<u>Where:</u>
<u>When:</u>			<u>Type:</u>
Probation referred			Name of PO:
Court referred			Name of Court:
Lawyer referred			Name of Lawyer:
Legal charges:			What are the charges:
Substances involved:			Type of Substances:
Self referred			

Primary Dr.:________________________ Where: _________________ Ph#___________Date last visit_______

MAT Dr.:______________________ Where: ______________Ph#______________ Date last visit___________

Current Medications (remind to bring list)____

____

Reason for seeking treatment or history:

____

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Clinician Assigned:________________________ Person taking referral:________________________________

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If MAT Physician assigned to:___________________________ Dr. Appt Date/Time________________________