www.anglezbhs.com 1-844-294-5306 fax

Substance Use Disorder Treatment

Date of Referral _____ Initial Appt. date/time_____ Assigned to _____
Referral Source _____
Treatment requested (please check): SUD/OPT _____ MAT_____

First:	Last:	M:
DOB	SSN:	Gender:
Ins/Medicare#	Ins/Mainecare#	Self Pay ____Y ____N
Place of Employment:		Job Title:
Please check: _____married _____ Single _____ Separated _____ Widow _____Divorced _____ Cohabitating		

Current Residence:

Street:		Town:	
State: Maine	Zip:	Phone #:	Leave message? __Y___N

History	YES	NO	Detail
Previous Treatment			Where:
When:			Type:

(If Applicable)
MAT Dr.:_____ Where: _____Ph#_____ Date last visit_____
Are you currently taking medications ☐Yes ☐ No (Remind to bring medication list to first appt)
Reason for seeking treatment or history:

_____
_____
_____

Person taking referral:_____

Edited 4/11/2018