Pascal Crisis Services, Inc.
Robert A. Pascal Youth & Family Services, Inc.
741 Annapolis Rd, Gambrills, MD 21054
(410) 975-0067

# Intensive Outpatient Program Services (ASAM 2.1) Referral Application

Date of Application: _____

## Referral Source

Name: _____ Title: _____

Organization: _____ Phone: _____

Address: _____ City/State/Zip: _____

## Client Information

Name: _____ Age: _____ DOB: _____/_____/_____

Sex: Male ☐ Female ☐ SSN: _____-____-_____ Photo ID? Yes ☐ No ☐

Type of Insurance: _____ ID #: _____

## Medical Information

Do you have any allergies? Yes ☐ No ☐ *If yes, please list below:*

| *Allergy* | *Reaction (e.g. Hives, Swelling, Difficulty Breathing, etc.)* |
|---|---|
| | |
| | |
| | |

Medical Conditions:

Primary Care Provider: _____ Phone: _____

## Current Medications

| *Medication Name* | *Dose* | *Route* | *Frequency* | *Prescriber Name* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Behavioral Health Information

DSM 5 Diagnosis: _____

Substance Use History:

| *Substance Used* | *Length of Use* | *Route of Use* | *Amount Used* | *Last Use (Date/Time)* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Prior Overdoses? Yes ☐ No ☐

If yes, How many: _____ Dates: _____

Prior Seizures? Yes ☐ No ☐

If yes, How many: _____ Dates: _____

Prior Treatment (Inpatient and Outpatient):

_____

_____

_____

Plan (ASAM Level):

_____

_____

_____

_____ _____

*Referral Source Signature with credentials* *Date*