UNITED QUEST CARE SERVICES LLC

REFERRAL FORM

Please note, information missing from fields means the form cannot be processed and will have to be returned.

Member details

Title		Record #	
Surname		Date of Birth	
First name(s)		Social Security #	
Address			
Town/City		Suite/Apt	
Telephone		Zip Code	
Marital Status		Race/Ethnicity	
Identifying Gender		Gender at Birth	
Legal Guardian		Consent to Release	
Relation to member		Telephone	

Referred By

Name		Referral Date	
Affiliation		Telephone	

Service/Services Requested

Diagnostic Assessment	☐	Peer Support	☐	MAT-Buprenorphine/Suboxone(TBA)	☐
Psychiatric Assessment	☐	Individual Support	☐	SACOT	☐
Medication Management	☐	PSR	☐	SAIOP	☐
Outpatient Therapy	☐	Urinalysis	☐	DWI Services(TBA)	☐
Other:					

Treatment History (Current or Past)

Mental Health Tx and Date	
Substance Abuse Tx and	

Insurance

Primary Insurance		Subscriber ID	
Secondary Insurance		Subscriber ID	
MCO (if applicable)			

Presenting Problems or Reason for Seeking Services

IN HOUSE ONLY:

APPT DATE:			**CLINICIAN:**			**TIME:**	
INSURANCE VERIFIED:			**NOTIFIED CLINICIAN:**			**PROGRAM:**	
URGENCY:	**EMERGENT (24hrs)**	☐	**Urgent (48hrs**	☐	**Routine (7 days)** ☐	**Court Mandated:**	☐
NOTES:							

Staff receiving Referral: _____Date: _____

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