|  |
| --- |
| With this signature, I agree to release my information to the secondary contact, confirm future appointments, and to release my information to the counselor listed below.  \*Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Medication Assisted Treatment Patient Demographic Sheet

Vivitrol Referrals for Positive Recovery Solutions

FAX to: (724) 249-2825 / Phone: (412) 660-7064

\*County of Referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Sex: M or F

\*DOB: \_\_\_\_\_\_\_\_\_ \*SS#: \_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \*Valid Phone Number: \_\_\_

\*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

\*Drug of choice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Outpatient Drug & Alcohol Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Name of Vivitrol Coordinator / Lead Therapist / Lead Counselor at Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Phone Number / Email For Vivitrol Lead at Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Patients Counselor Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Person making the referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Email/Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Insurance: Y or N (Attach copy of insurance card)

\*Primary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_ \*ID/Group# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_ ID/Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Patients Secondary Emergency Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note(s): \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_