SUBSTANCE USE ASSESSMENT REFERRAL

Client Information

Full Name: _____

Date of Birth: _____

Address: _____ **City / State / ZIP:** _____

Phone: _____ **Email:** _____

Referral Source

Name / Title: _____

Organization / Agency: _____

Phone: _____

Email: _____

Reason for Referral / Presenting Concerns

_____

_____

Insurance / Payment Information

Insurance Company: _____

ID #: _____ **Policy Number:** _____

Does the client have more than one insurance policy? ☐ Yes ☐ No

Self-Pay / Other: _____

Referral Details

Urgency / Notes: _____

Consent for Release of Information (if applicable): ☐ Yes ☐ No

FAX COMPLETED FORM TO: (763) 244-1243

For Serenity Circle Counseling Use Only

Date Received: _____

Contacted: _____

Scheduled Appointment: _____

Clinician: Traci Page, LPCC, LADC

Notes: _____