REFERRAL FORM

Touchstone Residential
Substance Use Treatment

55 RE Jennings Avenue SE ● Arlington, Georgia 39813
P: 229.725.3333 ● F: 229.725.3331 ● www.aspirebhdd.org

Date of Referral:_____

Individual Referred:_____

Address:_____

City:_____ State:_____ Zip:_____

Contact Numer(s):_____

Email Adress:_____

Date of Birth:_____ Social Security #:_____

Gender:_____ Race:_____

Education Level:_____ Marital Status:_____

Insurance Provider(s):_____

Is substance use treatment covered by policy: ☐ Yes ☐ No ☐ Unknown

● ●

Referral Source's Name:_____

Agency/Organization:_____

Address:_____

City:_____ State:_____ Zip:_____

Contact Numer(s):_____

Email Adress:_____

● ●

If individual has been discharged from any treatment facilities or hospitals, please attach the following documents:

☐ Discharge Summary ☐ Nursing Assessment ☐ Physical Exam ☐ Labs ☐ Psychiatric Evaluation

R E F E R R A L F O R M

Touchstone Residential Substance Use Treatment

Individual Referred:_____

Reason for Referral:_____

Substance Use History *(include current and past use of alcohol, illegal drugs, and/or prescription drugs):*

Treatment History *(include current and past):*

Social History *(environment, family & relationships, family addiction history, significant events, legal history):*

Individual's Strengths and Needs:

● ●

Current Medications:_____

_____

Allergies:_____

Name of Physician:_____

Date of last Physician's Examination:_____

Medical History *(including psychiatric history):*