UPC INC.

RECOVERY NETWORK

Recovery Network Referral **FAX TO: 410-889-4167**

Referral Source:_____ **Phone:**_____ **Date:**_____

Patient Name:_____ **DOB:**_____ **Age:**_____ **Sex:**_____

Current Address:_____ **City/State/Zip:** _____

Drug(s) of choice/Last date of use: _____

INSURANCE

Policy Holder:_____ **Relationship to Patient:** _____

Insurance:_____ **ID#** _____

Precipitating Event:_____

Current or Previous MH& SUD Diagnosis: _____

Current Medications: _____

Current Mental Health Provider (social workers, counselors, psychologist, and/or psychiatrist): _____

Suicidal or Homicidal Thoughts/Plans:_____

Legal Stipulations (probation/parole/open court date): _____

MH/SUD Treatment program in the past: _____

(Methadone/Suboxone): _____ **if yes: Dose/Provider:**_____

Does patient report wanting to be enrolled in MAT?_____

****Must be stable and not require immediate nursing care or medical attention within 48-72 hours****

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