Please attach the following with this referral

- Signed Release of Information
- Face Sheet with Patient Demographic + Insurance Information
- Initial assessment, medication sheet and discharge instructions
- If referring from inpatient treatment facility- please include blood work results

OUTPATIENT SUBSTANCE ABUSE PROGRAM REFERRAL FORM

REFERRAL TO:	**REFERRAL FROM:**
NAME: New Life Medical Addiction Services	**NAME:**
ADDRESS: 773 East Rt. 70, Suite E-100	**ADDRESS:**
Marlton, NJ 08053	
PHONE: 856-942-3700	**PHONE:**
FAX: 856-452-5758	**FAX:**

DATE OF REFERRAL:	**PATIENT'S NAME:**
PATIENT'S PHONE NUMBER:	**DATE OF BIRTH:**
SEX: [ ] **Male** [ ] **Female**	**INSURANCE CARRIER/ID#:**
HAS THIS PATIENT BEEN DISCHARGED FROM YOUR PRACTICE? [ ] **Yes** [ ] **No**	
PERMISSION TO CONTACT OBTAINED? Please include ROI [ ] **Yes** [ ] **No**	
IS THE PATIENT AWARE WE WILL CONTACT THEM? [ ] **Yes** [ ] **No**	

REASON FOR REFERRAL:
[ ] Detoxification from opioids
[ ] Detoxification from alcohol
[ ] Medication Assisted Treatment (MAT) services
[ ] Drug and alcohol treatment (PC, IOP, OP)
[ ] Co-Occurring disorder treatment (PC, IOP, OP, Medication Management)
[ ] Other:

_____

_____

CHECK OFF SUBSTANCE INVOLVEMENT:
[ ] Tobacco products [ ] Alcohol [ ] Prescription opioids [ ] Heroin [ ] Cannabis
[ ] Cocaine [ ] Prescription stimulants [ ] Sedatives/sleeping pills [ ] Methamphetamine
[ ] Other- specify:

SIGNATURE OF REFERRING PROVIDER: