Referral Form

Date of Referral_____

Please Include the Following:

1. Referral Page
2. Substance Abuse Assessment – Most Recent
3. Contact Phone Number
4. Current Valid Driver's License/State ID – Send Copy

Full Name: _____ _____ _____
Last *First* *M.I.* *Age* *Date of Birth*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code* *Phone*

County of Legal Residence:_____ Social Security No.:_____ Marital Status:_____

Race:_____ Hispanic: YES ☐ NO ☐ Veteran: YES ☐ NO ☐ # of Dependents:_____

Education Level:_____ Annual Gross Income:_____ Income Source:_____

SSI/SSDI Eligible: YES ☐ NO ☐ Insurance: YES ☐ NO ☐ EPC or MHB: YES ☐ NO ☐ Suicide Attempts in Last 30 Days: YES ☐ NO ☐

Prior to Treatment Living Arrangements: ALONE ☐ W/RELATIVES ☐ W/NON-RELATED ☐ Type of Residence:_____

Legal Status:_____ # of Arrests in Last 6 Months:_____ IV Drug User: YES ☐ NO ☐

Medical / Mental Health Diagnosis (Specify): _____

Infectious Disease Screening: Testing for Hepatitis A ____B ____C ____HIV: _____ Results: _____
At-risk behaviors for infection: IV use / shared needles _____ Unprotected sex with unknown status _____

Medications:_____

_____

_____ Refills available?: _____

Dr / Prescriber: _____ Appointments scheduled? _____

	1st Drug of Choice		2nd Drug of Choice		3rd Drug of Choice	
Name of Drug						
Age of 1st Use/Date Last Use						
Use in Past Month/How Often?	YES NO		YES NO		YES NO	
Volume/Per Day, Week, or Month						
Route (Oral/Nasal/Smoke/IV)						

Please Return to William Nuss, Admissions Coordinator
Phone: 402-371-5310
Fax: 402-371-7483
Email: wnuss@link-recovery.org

Referral Form

Date of Referral_____

# of Prior Treatment Episodes:_____

Where: _____Admission Date:_____Expected Discharge Date: _____

Where: _____Admission Date:_____Expected Discharge Date: _____

Where: _____Admission Date:_____Expected Discharge Date: _____

Where: _____Admission Date:_____Expected Discharge Date: _____

Where: _____Admission Date:_____Expected Discharge Date: _____

Referred By (Counselor): Counselor Signature:_____

Referral Taken By? _____

Date: _____

Form Revised 4/2021

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