Counseling Solutions

of the Lehigh Valley

PATIENT REFERRAL FORM

REFERRAL DATE:______________ **REFERRING AGENCY:** ______________________________

Client Name: ____________________

DOB / SSN: ____________________

Address: ____________________

Phone Number: ____________________

Counselor/Referral Contact Name: ____________________

Counselor/Referral Contact Email: ____________________

Counselor/Referral Tel#: ____________________

Level of Care: ____________________

SUBSTANCE USE HISTORY

Drug of Choice: ____________________

Secondary DOC: ____________________

Current Pattern and Last use: ____________________

Method of use: ____________________

MAT History: ____________________

Megan's Law? **NO** **Yes**

SEND ASAM Summary, BIOPSYCHOSOCIAL, AND A COPY OF THE FRONT AND BACK OF THE CLIENT'S INSURANCE CARD (IF applicable).

PLEASE email to: referral@csolv.org

1329 Hamilton St 2nd fl., Allentown, PA 18102 | PO Box 1485, Allentown, PA 18105
(610) 756-1765 | CounselingSolutionsLV.com | Info@CSOLV.org | FB/IG @CSOLV101