Outpatient SUD Referral Form

Referral Agency:		**Referral Date:**	
Referral Name:		**Referral Phone:**	

Client Information			
Client Name:		**Address:**	
DOB:		**City / State:**	
Phone:		**Zip:**	

Insurance Information	
Insurance Carrier:	
Insurance ID#:	
Insurance Group#:	

Comprehensive Assessment Completed?	☐ Yes ☐ No
Date Comprehensive Assessment Completed:	
Location Comprehensive Assessment Completed:	

Preferred Treatment Location:	☐ Duluth ☐ Cloquet	**Level of Treatment:**	☐ ASAM 2.1 ☐ ASAM 1.0

Please send to: info@WebMedMN.com or via fax (218) 206-6276