A.I.D. SOCIAL SERVICE AGENCY/ REFERRAL FORM

PATIENT NAME____

PATIENT ADDRESS____

CITY________________________ ZIP___________________ DOB______________ DOD______________

INSURANCE____

SS#___________________________________ PHONE#____

INSURANCE ID_________________________________ GROUP#____________________________________

INSURANCE PHONE#____

LEVEL OF CARE (PLEASE CHECK THAT IS APPICABLE)

☐ THERAPY
INTENSIVE OUTPATIENT: ☐SUBSTANCE ABUSE ☐ MENTAL HEALTH ☐EATING DISORDER
☐ PSYCHAITRIST

WHAT IS YOUR DIAGNOSIS PER YOUR PAST PSYCHAITRIST OR THERAPIST?___________________________

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WHAT ARE YOUR CURRENT MEDICATIONS?

NAME	DOSE

BRIEF SUMMARY FOR REFERRAL (BE SPECIFIC FOR BEHAVIOR OF PAST 3 DAYS)

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PLEASE FAX TO 404.393.6439 AND INCLUDE THE FOLLOWING: A REPRESENTATIVE WILL CALL WITHIN 4 HOURS OF FAXED REFERRAL.