Referral for Substance Use Disorder and Related Services

* indicates required field

For non-required fields, enter enough information for the Referred To agency to determine if they can meet the client's specific needs.

Field Name	Description
Referring Agency Information	
Name of Agency*	Choose your agency from the drop down. If not included in the listing, choose Not Listed.
Agency Name if not listed	This box opens when Not Listed chosen in Agency Name. Enter your agency name.
Date	Defaults to the current date. Choose the date or enter the date you are making the referral in this field in mm/dd/yyyy format
Primary Contact Name *	Enter the name of the Primary person at your agency to contact in case of questions from Referred To agency.
Email*	Enter the email of the Primary person at your agency to contact in case of questions from Referred To agency.
Phone Number *	Enter the telephone number of the Primary person at your agency to contact in case of questions from Referred To agency. Enter the numbers only starting with the area code; the form will auto fill the () around the area code and the dash between first three and last four of the telephone number. For example, enter 9999999999 and the form will format as (999)999-9999.
Extension	Enter the telephone number extension of the Primary person at your agency to contact in case of questions from Referred To agency.
Secondary Contact Name	Enter the name of the Secondary Contact person at your agency to contact if the Primary Contact is unavailable in case of questions from Referred To agency.
Secondary Email	Enter the email of the Secondary Contact person at your agency to contact if the Primary Contact is unavailable in case of questions from Referred To agency.
Secondary Phone	Enter the telephone number of the Secondary Contact person at your agency to contact if the Primary Contact is unavailable in case of questions from Referred To agency. Enter the numbers only starting with the area code; the form will auto fill the () around the area code and the dash

	between first three and last four of the telephone number. For example, enter 9999999999 and the form will format as (999)999-9999.
Extension	Enter the telephone number extension of the Secondary Contact person at your agency to contact if the Primary Contact is unavailable in case of questions from Referred To agency.
Agency Fax Number	Enter the Fax number at your agency that would go to the Primary or Secondary contact person. Enter the numbers only starting with the area code; the form will auto fill the () around the area code and the dash between first three and last four of the telephone number. For example, enter 9999999999 and the form will format as (999)999-9999.

Release of Information *	
Is there a Release of Information attached to this referral?	Indicate if you are attaching a Release of Information, either generic or your agency specific, to the referral. A ROI should be transmitted with the Referral if required.
Will the client remain in services with the referring agency?	Indicate if you will continue providing services to the client.
Feedback is requested	Indicate if you want to get feedback about the client from the target agency.
Please indicate type of feedback requested	Include comments about your ongoing services to the client or feedback you wish to receive. For example, "We will continue serving the client by providing the client medication" or " Please let us know if the client has appeared for assessment."

Agency Being Referred To	
Name of Agency	Choose the target agency from the drop down. If not included in the listing, choose Not Listed.
Agency Name if not listed	This box opens when Not Listed chosen in Agency Name. Enter target agency name.
Service Site	Name of the specific location/site to which the client is being referred.
Site Street Line 1	Address line 1 of the site where the client is being referred.
Site Street Line 2	Address line 2 of the site where the client is being referred. This would be such things as Suite or Room number
Site City	City of the site where the client is being referred.
Site State	State of the site where the client is being referred. Usually, Indiana which is first choice in dropdown.
Site Zip Code	Zip code where the site is located.
Primary Contact Name, if known	Enter the name of the Primary person, if known, at the target agency for the client to contact

Email	Enter the email of the Primary person, if known, at the target agency for the client to contact
Phone Number	Enter the telephone number of the Primary person at the target agency for the client to contact. Enter the numbers only starting with the area code; the form will auto fill the () around the area code and the dash between first three and last four of the telephone number. For example, enter 9999999999 and the form will format as (999)999-9999.
Fax Number	Enter the Fax number at the target agency. Enter the numbers only starting with the area code; the form will auto fill the () around the area code and the dash between first three and last four of the telephone number. For example, enter 9999999999 and the form will format as (999)999-9999.
Purpose of Referral	
Purpose of Referral	Enter the purpose for which you are referring this client to the target agency. Specify what are you asking to be done, what services rendered, why are you making the referral at this time to this place.
Client Information	
Legal First Name	Legal name of Client -first
MI	Middle Initial of Client
Legal Last Name	Legal name of Client -last
Preferred Name	Name client prefers to be called
Date of Birth	Client Date of birth
Address	
Street Line 1	Address where the client can get mail. This could be a P.O. Box number or a physical address.
Street Line 2	Second line of client address for mail, e.g., Suite, Apt. Room number
City	City of the client's address for mail.
State	State of the client's address for mail.
Zip Code	Zip code the client's address for mail.
Phone Number	Client's telephone number. Enter the numbers only starting with the area code; the form will auto fill the () around the area code and the dash between first three and last four of the telephone number. For example, enter 9999999999 and the form will format as (999)999-9999.
Email	Client's email address.
Parent or Guardian (if under 18)	If the client is under 18, enter the name of Parent or Guardian
Gender	Select the gender the client identifies with or client may choose not to disclose.

Legal Gender	Select the legal gender of the client.
Personal Pronoun Preference	Select the pronouns by which the client wishes to be known or addressed as.
Is Client pregnant?	Indicate if the client is currently pregnant.
Client has access to video/phone conferencing?	Indicate if the client has the resources to connect either by telephone or videoconferencing.
Veteran	Check the box to indicate the client is a veteran.
Interpreter Services Needed?	Indicate if the client needs an interpreter for interaction either due to language or hearing impairment.
If Yes, please explain	If an interpreter is needed indicate details to allow the Referred to agency prepare. The additional information could indicate language limits, type of sign language, client has own interpreter, etc.
Does the client have a safe place to stay?	Indicate if the client is living in a safe situation.
Housing Status	Select the client's current living/housing situation.
Is the client at risk of losing housing in next 30 days?	Indicate if the client is losing their living situation in the next 30 days.
Provide details for any of the above questions, if appropriate	Provide relevant details about the client's living situation, e.g., being kicked out of house next week, reporting to jail on the 14th, etc.
Will the client need transportation assistance?	Indicate whether the client will need help getting to services at the target agency.
If Yes, provide details	Provide details regarding the client's need for help with transportation, e.g., has car but not money for gas, is on bus line needs bus pass, wheelchair bound no transport available.
Alternate Contact (someone who always knows where client is)	
Name	Enter the name of a person who maintains contact with the client in case of lost contact
Email	Email of the alternate contact
Phone Number	Telephone number of the alternate contact. Enter the numbers only starting with the area code; the form will auto fill the () around the area code and the dash between first three and last four of the telephone number. For example, enter 9999999999 and the form will format as (999)999-9999.
Payment Information	
Medicare	Check if the client has Medicare
ID#	Enter the client's Medicare number

Medicaid/HIP	Check if the client has Medicaid or HIP
ID #	Enter the client's Medicaid number
Veteran's Benefits	Check if the client has Veteran's benefits
Private Insurance (if checked, provide details below)	Check if the client has Private Insurance which could pay for services.
Company (up to three instances)	Name of private/commercial insurance
ID #	Client's ID number on private/commercial insurance policy
Group	Group ID number on private/commercial insurance policy
Plan	Plan number on private/commercial insurance policy
Policyholder Name	Name of Policy holder for the private/commercial insurance policy
Add (Delete)	Clicking this button adds another row (up to two additional) to the Private Insurance listing. Clicking the Delete button which appears next to the additional rows will delete the row.
Self-pay	Clicking this box indicates that the client intends to pay for services themselves.
No insurance, needs financial counseling	Clicking this box indicates the client does not have resources for payment and will need financial counseling to obtain coverage.
Potentially Eligible for Recovery Works	Clicking this box indicates the client potentially meets the requirements for Recovery Works payment.
Other	Check this box and fill in the details box if there is an Other payment type that might assist with costs.
If Other, provide details	Indicate details for any payment / cost assistance available to the client.
Medical Information	
Are there any medical or behavioral health concerns that need to be known for this referral?	Indicate if there is any medical information that would be good for the referred to agency to know to determine if they can accept the referral.
If Yes, provide details	Enter detailed information that would be helpful to the referred to agency.
Medication	
Is the client taking or needing to take any medications that need to be considered for this referral?	Indicate if there are medications or the need for medications that the target agency may need to know in considering this referral.

If Yes, provide details	Provide details of medication the target agency needs to know about
Time form completed	This field is auto field with the date and time when the form is completed and saved.
Save copy as PDF	Clicking this button creates a pdf of the completed form with the appropriate time stamp. The pdf should be saved to the local machine or network with the client name or whatever appropriate details your agency requires. The pdf along with a completed ROI, if appropriate, can be emailed, faxed, printed to refer the client to the target agency.