Adult Outpatient Treatment Program - Referral Form

It can get better! We're here to help!

Treatment for Substance Use Disorder starts here.

Is this referral urgent? ▫ Yes ▫ No

Valley Health Associates

RETURN COMPLETED REFERRAL REQUEST FORM TO			
ATTENTION	Valley Health Associates	FAX	(831) 424-9717
PHONE	(831) 424-6655	EMAIL	valleyhealthsalinas@gmail.com
FORM COMPLETED BY		PHONE	DATE

REFERRING PROFESSIONAL INFORMATION			
LAST NAME		FIRST NAME AND MI	
PRACTICE/ ORGANIZATION		SIGNATURE	
ADDRESS CITY, STATE, ZIP		PHONE	
		FAX	
		EMAIL	

CLIENT INFORMATION			
LAST NAME		FIRST NAME AND MI	
DATE OF BIRTH		GENDER	
INTERPRETER REQUIRED?		LANGUAGE REQUIRED	
CLIENT'S ADDRESS CITY, STATE, ZIP		CELL PHONE	
		May we leave a message on cell?	▫ Yes ▫ No
		HOME PHONE	
		May we leave a message at home?	▫ Yes ▫ No
EMAIL		May we email?	▫ Yes ▫ No *Note: Email is not considered to be a confidential medium of communication.
GUARDIAN NAME (if under 18 years)		GUARDIAN RELATIONSHIP	
REFERRAL DIAGNOSIS			ICD-9
TYPE OF INSURANCE (IF ANY)		COPY OF INSURANCE IS ATTACHED	▫ Yes ▫ No

REASONS FOR REFERRAL (PRESENTING PROBLEMS):

ANY HISTORY OF AGGRESSIVE BEHAVIOR AND/OR SELF HARM?

ANY RELEVANT MEDICAL OR PSYCHIATRIC HISTORY?

OFFICE USE:
Initial Appointment Set For Date/Time: _____

Counselor Name: _____

_____ _____
Counselor Signature Date

Valley Health Associates
427 Pajaro Street, Suite 4 | Salinas, CA 93901
(831) 424-6655 ph. (831) 424-9717 fax
ValleyHealthAssociates.com