**PLEASE SEND THIS REFERRAL FORM TO** [**RECOVERY@ASTRABH.COM**](mailto:recovery@astrabh.com?subject=FREEDOM%20RECOVERY%20IOP%20REFERRAL)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | | | | |
| **LAST NAME** | | | **FIRST NAME** | | | | **MI** |
| **DOB** | **AGE** | | **SSN** | | | | |
| **GENDER** | | **RACE/ETHNICIT** | | | **LANGUAGE** | | |
| **STREET ADDRESS** | | | | | | | |
| **CITY** | | | | **STATE** | | **ZIPCODE** | |
| **CELL PHONE #** | | | | **HOME PHONE #** | | | |
| **EMAIL** | | | | | | | |

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| --- |
| **INSURANCE INFORMATION** |

|  |  |
| --- | --- |
| **PRIMARY INSURANCE COMPANY** | |
| **POLICY #** | **GROUP #** |
| **SECONDARY INSURANCE COMPANY** | |
| **POLICY #** | **GROUP #** |

**REASON FOR REFERRAL TO RECOVERY CLINIC:**

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Substance use Medications

Evening IOP Group

Day-time IOP Group

|  |  |  |
| --- | --- | --- |
| **Referred By (Full Name):** | | **Referring Agency:** |
| **Contact Phone #:** | | **Contact Email:** |
| **How did you hear about us?** |  | |