New Horizons medical

TIME TO CHANGE

285 Main St.
Fitchburg, MA 01420
Tel: 978-499-0889
Fax: 978-488-0798
Email: info@newhorizonsmedical.org
Newhorizonsmedical.org

SUBSTANCE USE & RECOVERY INTENSIVE OUTPATIENT PROGRAM REFERRAL FORM

Date of Referral: ______________________________

Referring Provider: ______________________________

Address: ______________________________

Phone Number: ______________________________

Patient Name: ______________________________

D.O.B.: ______________________________

Primary Insurance: ______________________________

Current Level of Care: ______________________________

Patient Phone Number: ______________________________

Diagnoses: ______________________________

Describe Reason for Referral to Substance Use & Recovery IOP:

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▢ I have enclosed a copy of an authorization for release of information for the patient listed above and request that information regarding admission, treatment, and discharge planning be shared with me.

______________________________ ______________________________

Signature of Referring Provider Date