

PATIENT REFERRAL FORM**REFERRAL SOURCE**

Referrer Name	Organization	Phone
Email	Fax (optional)	Referrer Type
		☐ Provider ☐ Court/IDRC
		☐ Parole/Probation ☐ Detox
		☐ EAP/Employer ☐ Family/Self

PATIENT INFORMATION

Patient Name	Date of Birth	Phone
Email	Insurance Provider	Member ID (optional)

REASON FOR REFERRAL (check all that apply)

☐ Alcohol use	☐ Opioid use	☐ Other substance use
☐ Co-occurring mental health	☐ Court-ordered evaluation	☐ DUI / license matter
☐ Step-down from detox/residential	☐ Relapse / return to care	☐ Substance use evaluation only
☐ Other:		

CLINICAL INFORMATION

Current Diagnosis (if known)	Current Medications (if applicable)
Clinical Concerns / Notes	

PROGRAM PREFERENCE

☐ Day IOP (Mon-Thu, 9:30 AM-12:30 PM)	☐ Evening IOP (Mon-Wed, 6-9 PM; Mon in person, Tue/Wed virtual)
☐ Outpatient counseling	☐ Evaluation only ☐ First available

Submit Referral

Please fax or email the completed referral form to:

Fax: (732) 720-8323 Email: info@diamondcounselingcenter.net Phone: (732) 248-1805