ADOLESCENT REFERRAL FORM

TRUE NORTH CLINIC
Intercept Health

Please: (1) Complete this form, (2) Save it, and (3) EMAIL it to: **truenorthreferrals@interceptheath.com**

To make a referral by phone please call:
- 540.759.8209 (Substance Use)
- 540.523.8080, Opt. 1 (Psychiatric)

Main Office: 540.523.8080, Opt. 1
truenorthreferrals@interceptheath.com
5673 Airport Rd. NW, Roanoke, VA, 24012
Fax: 540.512.9775

Referral Date:

REFERRAL SOURCE INFORMATION

Agency Making Referral (if applicable):
Person Making Referral:
Email Address:
Address:
City: State: Zip Code:
Phone: Fax:

CLIENT INFORMATION

Client Name:
Date of Birth: Gender: ◯ Male ◯ Female
Email Address:
Address:
City: State: Zip Code:
Phone: Fax:
Health Insurance Provider: Policy Number:
Parent/Guardian Name:
Parent/Guardian Email Address:
Parent/Guardian Phone:

REASON(S) FOR REFERRAL

- ☐ Substance Use Disorder Assessment
- ☐ Outpatient SUD Education Groups
- ☐ SUD Intensive Outpatient Program (IOP)
- ☐ Psychiatric Medication
- ☐ Failed Urine Drug Screen - List Substance(s):
- ☐ Current Legal Charges - List Court Date(s) and charges:
- ☐ Failed Pill Counts
- ☐ Alcohol Abuse
- ☐ Discharged From Clinic
- ☐ Multiple Prescribers

Additional Comments:

PLEASE ATTACH ANY SUPPORTING DOCUMENTS (ROI, LABS, NOTES)

FOR INTERCEPT HEALTH OFFICE STAFF ONLY

☐ Screened ☐ Eligible ☐ Ineligible due to:

Screening Staff Signature: Date: