

ADULT REFERRAL FORM

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

Main Office: 540.523.8080, Opt. 1

truenorthreferrals@intercepthealth.com

5673 Airport Rd. NW, Roanoke, VA, 24012

Fax: 540.512.9775

To make a referral by phone please call:

- 540.759.8209 (Substance Use)
- 540.523.8080, Opt. 1 (Psychiatric)



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:

REASON(S) FOR REFERRAL

Substance Use Disorder Assessment

Failed Pill Counts

Outpatient SUD Education Groups

Alcohol Abuse

SUD Intensive Outpatient Program (IOP)

Discharged From Clinic

SUD Partial Hospitalization Program (PHP)

Multiple Prescribers

Residential (ASAM Level 3.1)

Psychiatric Medication

Failed Urine Drug Screen - List Substance(s):

MAR Services →

Sublocade

Suboxone

Naltrexone

Vivitrol

Current Legal Charges - List Court Date(s) and charges:

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: