Contentnea Health Bernstein
261 Belvoir Highway
Greenville, NC 27834

Contentnea Health Greene
1106 Kingold Boulevard
Snow Hill, NC 28580

Call 252-600-1200.

Psychiatric & MOUD Treatment Referral

Client Name: **Date of Birth:** **Gender: M /F**

Address: **City:** **Zip:**

Guardian: **Phone:** **Can we leave a message** Y / N

Interpreter Services needed: **Client:** Y / N **Guardian** Y / N **Language spoken:**

Primary Insurance: **Secondary Insurance:**

Group Number: Group Number:

Identification number: Identification number:

Phone #: Phone #:

Referral Source/Name: **Organization:**

Phone: **Fax:** **Email:**

Current Therapist: **Phone:**

Current Case Manager: **Organization:** **Phone:**

Is client aware of this referral: Y / N **Is the client in crisis? Y / N** **Was crisis information given? Y / N**

Diagnosis: **Current Symptoms:**

Current or history of violence or aggression: Y / N Please explain –

Current or past substance abuse: Y / N Please explain –

Current Psychiatric Medications and dosage: (attach list if needed) **Name of Prescription:**	**Dosage:**	**Prescribing MD/NP:**

If you are referring from a physician's office, please attach the latest visit summary with labs to this referral form.

Contentnea Health

Client name: _____

Suicide attempts: Y / N

Previous Psychiatric Hospitalizations: Hospital	**Date**	**Reason for Hospitalization**

Current or Previous Psychiatrists Name:	**Year:**

Medical History

Current Non-Psychiatric Medications and dosage: Name of Prescription:	**Dosage:**	**Prescribing MD/NP:**

Allergies

Reason for Referral (check all that apply)

☐ Psychiatric Evaluation / Ongoing Care

☐ MOUD Services

☐ Co-Occurring Mental Health & Substance Use Concerns

☐ Medication Management

☐ Counseling / Therapy

☐ Other: _____ .

MOUD Specific Information

☐ Request for Buprenorphine

☐ Request for Naltrexone (Vivitrol)

☐ Not sure, requesting evaluation

Has the patient previously received MOUD? ☐ Yes ☐ No

If yes, details: _____

Consent

I authorize the release of this information to the receiving provider for the purpose of referral, coordination of care, and treatment planning.

Signature of Patient (or Guardian): _____ Date: ____/____/_____

Signature of Referring Provider: _____ Date: ____/____/_____

OFFICE USE ONLY

Date Referral Received: _____ ***Date Insurance Verified:*** _____ ***Initials:*** _____