kathy ireland® Recovery Centers

E-FAX Referral Form

Referral Source Information:

Referring Person Name _____
Facility Name/Department _____
Telephone Number (____) _____
Fax Number (____) _____
Physical Address _____
Email Address _____

Patient Information:

First and Last Name _____
Preferred Name _____
Telephone Number (____) _____
Physical Address _____
_____
Email Address _____
Date of Birth _____ / _____ / _____
Social Security Number _____ - _____ - _____
Gender _____
Emergency Contact Name _____
Telephone Number (____) _____
Relation to Patient _____

Payment Source:

Responsible Party (If not the patient) _____
Relationship to Patient _____
Responsible Party DOB _____
Insurance Carrier Name _____
Member / Policy ID Number _____
Group Number _____

Laconia, NH Office
E-Fax: 855-796-2908

Williamson, WV Office
E-Fax: 304-200-4894

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Referring to ASAM Level of Care

☐ 1.0 – Outpatient

☐ 2.1 – Intensive Outpatient

☐ 2.5 – Partial Hospitalization Services

☐ 3.1 – Clinically Managed Low-Intensity Residential Services

☐ 3.5 – Clinically Managed High Intensity Residential Services

☐ 3.7 – Medically Monitored Intensive Inpatient Services

For hospital referrals, please include the following information:

☐ History and Physical Exam

☐ Current Medication List

☐ Allergies / Adverse Drug Reactions

☐ Current Treatment Plan and Nursing Notes

☐ Lab Test Results

Referring Source Name (Printed) _____

Referring Source Signature _____

Date _____

For Internal Use Only:

Date E-Fax Referral Form received: _____

Received by: _____

Follow-up completed on: _____

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