PLEASE FAX COMPLETED FORM TO: (352) 861-3134 PHONE: (352) 671-3130

*When possible, please attach a Demographic sheet/ Medical History

Patient Referral Form

Urgent: _____ Routine: _____

******Please indicate which service(s) you are referring your patient for******

Intensive Outpatient 3x week _____ Partial Hospitalization 5x week _____ Detox _____
Inpatient Psych _____ Unsure/Free Assessment to determine appropriate level of care _____

Date of Referral: _____

Referring Dr. or Facility Name (Please PRINT Name) _____

Contact Person Name: _____ Office Phone #: _____

PATIENT INFORMATION

Patient Name: _____ Patient DOB: _____

Patient Address: _____

Patient Phone Number(s): _____ SSN: _____

Symptoms/Reason for Referral: _____

Insurance: _____ Policy #: _____

Group #: _____

The Vines provides Confidential/Free Assessments 24/7 with NO APPOINTMENT NECESSARY. If you have instructed your patient to come to the Vines for treatment, please indicate the date/time you have instructed them to arrive.

Date/ Time: _____

Contacts: Samantha Poulin, Director of Business Development: (352) 667-3198