DEAF ADDICTION SERVICES AT MARYLAND (DASAM)

1001 W. Pratt Street ♦ Baltimore, Maryland 21223

REFERRAL FORM

Date: _____

Patient's Name: _____ SSN: _____ - ____ - _____

Date of Birth: _____ Male or Female *(circle one)*

Deaf or Hard-of-Hearing *(circle one)*

Contact list **Ok for us to contact you?** ***(Yes or No)***

Home: (____) _____-_____ Yes/No

Work: (____) _____-_____ Yes/No

E-mail: _____ Yes/No

Other: _____ Yes/No

Referral Source

Contact Person's name: _____ Agency's name: _____

Agency's address:_____

Agency's phone number/fax number: _____

Insurance Information

Medical Assistance number (MA): _____

Medicare Number (MC): _____

Private Insurance company name: _____

Insurance policy number: _____

Insurance group number: _____

Other insurance coverage (non-primary) policy/group number: _____

_____ _____

Referral source Date

"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

ADMINISTRATIVE OFFICE
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