

DEAF ADDICTION SERVICES AT MARYLAND (DASAM)

630 W. Fayette Street ♦ Baltimore, Maryland 21201

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."

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