



Phoenix Center

Prevent • Treat • Recover

OUTPATIENT REFERRAL FOR AOD SERVICES

Date of Referral: _____

Client Name: _____ DOB: _____ Phone Number: _____

Referral Name: _____ Phone Number: _____

Adult Assessments are offered on a walk-in basis on **TUESDAY & THURSDAY at 8:30AM and 12:00PM**. You can assign a specific date and time below. **For pregnant and/or IV users, call (864) 467-3737 to schedule an appointment with priority.**

Appointment Date: _____ Time: 8:30AM 12:00PM

Please bring the following to your appointment: Photo ID, any medications you are currently taking, and Medicaid and/or Insurance card(s). Plan to stay for 2-3 hours to complete the assessment process.

REASONS FOR REFERRAL

REPORTED SUBSTANCES OF USE

Opiates (pain meds)	THC	Benzos (Valium, Xanax, etc.)
Methamphetamine	Cocaine	Alcohol
Amphetamine	Heroin	Other: _____

Client's reported last date of use: _____

DRUG TEST RESULTS (PLEASE ATTACH)

Date: _____ Hair _____ Urine _____ Negative _____ Positive: _____

*Please send completed form to **Records Department by fax (864) 467-3948.***