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 **Monday thru Thursday at 8:15AM**. You can assign a specific date to enroll by below. **Pregnant and/or IV users are given priority.**

Appointment Date: _____

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)
☐ Methamphetamine
☐ Amphetamine
☐ THC
☐ Cocaine
☐ Heroin
☐ Benzos (Valium, Xanax, etc.)
☐ Alcohol
☐ 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.***

PO Box 1948 ▪ Greenville, SC 29602 ▪ 864.467.3790 ▪ phoenixcenter.org
The Greenville County Commission on Alcohol and Drug Abuse