



# Community Integrated Health Services

## Substance Use Disorder Outpatient Referral Form

Our SUD Outpatient program offers all levels of care to include Outpatient, intensive Outpatient, DUI assessments and deferred prosecution treatment. We work closely with other programs both internally and externally to meet the needs of the individuals to include detox placement and residential coordination.

**This is a voluntary program for individuals who are eligible for Medicaid**, who have a primary behavioral health diagnosis, and who meet program eligibility standards.

### Instructions:

- Please complete this referral form and attach a copy of your insurance card and any additional information if available.
- Submit this referral form and any attachments in person or via:
  - Email [Scheduling@cihealthservices.com](mailto:Scheduling@cihealthservices.com)
  - Fax: (844) 554-3370 or (360) 748-4480
  - Postal Mail (see last page for mailing addresses.)
- CIHS will confirm receipt of the referral and will contact you within one business day of receipt of request.
- Check the county where you anticipate services being provided:
  - Cowlitz       Lewis       Grays Harbor
- How did you hear about us? \_\_\_\_\_

### Referent Information

Are you Self Referring?  Yes  No (if yes skip to next section)

Agency Name: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact Email Address: \_\_\_\_\_

### Individual Requesting Services

First & Last Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Preferred Gender Pronoun: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**Reason for Requesting Services**

Referred by a Provider. Who: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Legal Issues: \_\_\_\_\_

Pending Charges: \_\_\_\_\_

Employment Related Issues: \_\_\_\_\_

Self-Motivated Reasons: Explain:

Other: \_\_\_\_\_

**Diagnosis (If Known) and/or Symptoms**

Previous Substance Use Treatment in the past to include outpatient, residential, and/or detox.

No  Yes

If yes, with who and when: \_\_\_\_\_

Did you successfully complete the treatment?  Yes or  No

If no, what happened in your words?

Anything else you would like us to know about what brought you to CIHS?

**Community Integrated Health Services Mailing Addresses:**

**Cowlitz County:** 1128 Broadway, Longview, WA 98632

**Grays Harbor County:** 618 W. Market Street, Aberdeen, WA 98520

**Lewis County:** 1707 Cooks Hill Road, Centralia, WA 98531

Phone: (360) 261-6930 or (855) 303-4834 | Fax: (360) 748-4480 or (844) 554-3370

Website: [www.cihealthservices.com](http://www.cihealthservices.com)

**For Office Use Only:**

Received By: \_\_\_\_\_ Date: \_\_\_\_\_

Received Via:  Email  Fax  Mail  In-Person  Other \_\_\_\_\_

Provider One # \_\_\_\_\_