Referral Form

Please include this cover sheet and Fax to 928-299-2096

Referring Entity: ____

Name/Position/Contact of staff providing referral:

Staff Name: ______________________________ Title: ______________

Contact Info: ____

Desired level of follow-up communication requested:
High (daily)   Medium (weekly)   Low (bi-monthly)   None

Desired Referral Criteria

Face sheet
Negative COVID Test (within 48 hours)
Labs/Blood Alcohol Levels (within 2 hours)
Medical records
Acknowledgment that the clients potential withdrawal needs can be safely managed in a 3.5 level setting
Biomedical problems if any are stable and do not require 24 hour medical or nurse monitoring.
Nursing Notes/Physician Notes
30 days of RX Medications
Resident is capable of daily self-care activities
TB test results (preferred)

Any other pertinent information

Tel: 928-296-8898   Fax: 928-299-2096
2150 Silver Creek Road, Bullhead City, AZ 86442