Referral Form

Please include this cover sheet and fax to 928-299-2096 or email to c.getz@rivyve.com and l.armstrong@rivyve.com

Referring Entity:____
Name/Position/Contact Info of person submitting referral:
Name:________________________Title:___________________________
Contact Info:____

Desired Referral Criteria

- ASAM
- Behavioral Health Assessment or Bio/Psycho/Social
- Acknowledgment that the client's potential withdrawal needs can be safely managed in a 3.5 level setting
- Treatment Plan
- Psych Eval (if applicable)
- Medication List (if applicable)
- Biomedical problems, if any, are stable and do not require 24 hour medical or nurse monitoring
- Resident is capable of daily self-care activities
- If a referral is on any kind of daily prescribed medication (for physical or mental health), they must have a 30 day supply of these medications along with refills for those medications.
- Phone number for your client so Rivyve can do a pre-admission screening after receipt of referral.

Any other pertinent information