ABHC℠
Appalachian Behavioral Healthcare Center

REFERRAL FORM FOR PROVIDERS

Date of Referral:

Client Demographic Information	
Client Name:	**Client Date of Birth:**
Client Phone Number:	**Client Email Address:**
Client Physical Address:	
Insurance Information	
Insurance Provider:	**Insurance Policy Number:**
Clinical Information	
Primary Diagnosis:	
Reason for Referral: □ Substance Use Disorder □ Substance Use Disorder & Mental Health	
Please List Any Current Medications(Name and Dose, Attach List if Preffered):	
Does the Client have any Medical Conditions That May Require Monitoring? □ Yes □ No If so, please list.	
Was the Client Assessed for Suicide Risk by the Referring Agency? □Yes □ No If so, please provide the associated assessment/documentation.	
Referral Information	
Name of Referring Agency:	**Contact Phone Number:**
Name of Referring Person:	**Contact Phone Number:**

(681) 205-8940 ext. 101 // intake@abhcwv.org

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PROGRAM APPLICATION FOR INTERESTED PARTIES

Client Demographic Information	
Client Name:	**Client Date of Birth:**
Client Address:	
Client Phone Number:	
Gender you identify with: □ Female □ Male □	
SNAP benefit utilization consent (Sign Full Name): _____	
Insurance Information	
Insurance Provider: □ Aetna □ Unicare □ The Health Plan □ Other:	
Member ID Number:	
ABHC will bill your insurance for services provided:	**□ Yes □ No**
History of Use	
Anticipated date of discharge from detox:	
How long have you been using:	**Date of last use:**
How often did you use:	**Drug of Choice:**
Are you experiencing Withdrawal Symptoms: □Yes □ No	
Previous Treatment	
Facility:	**Location:**
Dates:	**Did you complete the program: □Yes □ No**
Facility:	**Location:**
Dates:	**Did you complete the program: □Yes □ No**
Facility:	**Location:**
Dates:	**Did you complete the program: □Yes □ No**

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PROGRAM APPLICATION
INTERESTED PARTIES

Legal	
Are you currently incarcerated/sentenced to jail: □ Yes □ No	
For what offense:	
Are you currently on probation, temporary absence, parole: □ Yes □ No	
List all previous violations and offenses, and dates:	
List upcoming court dates:	County:
Name of Parole officer:	Phone:
Name of CPS worker:	Phone:
Mental Health	
List any mental health conditions you have been diagnosed with currently or in the past:	
Have you had recent suicidal thoughts/actions?	
Are you currently being treated for them: □ Yes □ No	Physician or therapist name:
Medical history	
Respiratory (Asthma, COPD, Etc)	
Cardiovascular (Hypertension, Arrhythmia, Pacemaker, SVT, AFIB, Etc)	
GI (GERD, GI Bleeding, Hepatitis, Pancreatitis, Cirrhosis, Etc)	
Musculoskeletal (Chronic Pain, RA, OA, Gout, Etc)	
Integumentary (Psoriasis, Eczema, Skin Disorders, Etc)	
Immune (HIV, HCV, Etc)	

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PROGRAM APPLICATION
INTERESTED PARTIES

Neurological (Seizure, Migraine, Head Injury, MS, Stroke, Etc)	
Past Surgeries:	
Current Medications:	
Diabetes: □ Yes □ No	**□ Type 1 □ Type 2**
Are you on insulin: □ Yes □ No	**How often:**

List any known allergies: (Medications, Environmental, Chemical, Seasonal, Etc)	
Are you allergic to bee stings, poison ivy, poison oak, sumac, etc: □ Yes □ No	
Do you have a prescription for an Epipen: □ Yes □ No	
Do you smoke:	**□ Cigarettes □ Vapor □ Smokeless Tobacco**
Are you able to walk and take care of personal hygiene without assistance: □ Yes □ No	
Living Arrangements	
What is your current living situation: □ Own/rent □ Live with family □ Live with friends □ Live in sober living □ Unhoused	
By signing below, I am acknowledging my understanding that my application for participation into this program is not a guarantee for admission. I further understand that upon acceptance to the program, my insurance will be billed for services rendered and my SNAP benefits will be utilized throughout the course of my stay.	
Printed Name:	**Signature:**
Date:	