1606 Physicians Drive, Unit 104
Wilmington, NC 28401
Telephone: 910.343.6890 Fax: 910.332.1233

SUBSTANCE ABUSE INTENSIVE OUTPATIENT PROGRAM REFERRAL FORM

Date of Referral: _____

Referring Physician/Therapist: _____
Address: _____
_____
Phone: _____

Patient Name: _____ D.O.B. _____

Primary Insurance: _____Current Level of Care: _____

Client Phone Number: _____ _____

Diagnoses: Axis I _____
Axis II _____

Describe reason for referral to IOP:

_____

_____

_____

☐ I have enclosed a copy of an authorization for release of information for this client and request that information regarding admission, treatment and discharge planning be shared with me.

_____ _____
Signature of referring physician/therapist Date