2200 Garrison Boulevard
Baltimore, MD 21216
(240) 204-5594

REFERRAL FORM

Referral Date: ______________________________

Referral Source:	**Self** _____	**P&P** ______	**SUD Provider** ____	**MH Provider** ____
Referral Type:	**MAT** ____	**IOP** _________	**OP** _________	**MH** _______

Referred By: ____

Referral Agency: ____

Address: ____

Phone: ____

Consumer's Name _________________________________ **Age** _____ **DOB** ____________

Address ____

City_______________________ **State** ____________________ **Zip** ________________

Social Security Number _________________________ **Phone #** ____________________

Education Level – HS Diploma GED Some College Degree

Ethnicity Black White Hispanic Other Veteran Yes No

Marital Status Single Married Divorce Separated

Income Status Employed Public Assistance SSI/SSDI Unemployment None

Insurance _______________________ **MA#** ________________________________

Insurance Verification Yes No **Expiration Date** ________________________

Emergency Contact ____

Substances Used ____

Reported Date of Last Use ____

Mental Health Diagnosis____

MH Medications____

Intake Schedule Date ____

Omnis Staff Signature/Date ____