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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | |  | |  | | | | | |  | |
| Patient Name: | |  | | | | | | | | | | | |  | | Patient DOB: | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| Parent/Guardian Name:  (for children under age 18) | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| Patient/Parent/Guardian Phone #: | | | | | | | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| Patient/Parent/Guardian Preferred Language:  (if other than English) | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| Insurance Carrier: | | | 🞏 AHCCCS | | | | | | 🞏 Other | | |  | | | | | | |  | | | | |
| \*\* PLEASE ATTACH COPY OF INSURANCE CARD | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| Reason For Referral: | | | |  | 🞏 Alcohol Abuse | | | | | | 🞏 Drug Abuse | | | | 🞏 Depression | | | | | | | | 🞏 Anxiety |
|  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | 🞏 Psychosis | | | | | | 🞏 Suicidality | | | | 🞏 Other | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| Type of Service Requesting: | | | |  | 🞏 Individual   therapy | | | | | | 🞏 Group   Therapy | | | | 🞏 Psych Eval | | | | | | | | 🞏 Unknown |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| Comments/Considerations/Notes: | | | | | | | |  | | | | | | | | | | | | | | | |
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| **REFERRING PROVIDER CONTACT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| Referring Provider’s Name: | | | | | | |  | | | | | | | | | | Phone #: | | | |  | | |
| Contact: |  | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | |  | | |  | | |
| Address: |  | | | | | | | | | | | | | | | | | Fax #: | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| Referring Provider is: | | | | 🞏 PCP | | | | | | 🞏 Specialist  (please indicate specialty) | | |  | | | | | | | | | | |

Fax or email referral form to CODAC’s Enrollment Department.

Fax: (520) 202-1799 Email: [enrollment@codac.org](mailto:enrollment@codac.org)

**Questions? Call (520) 202-1840. Download this form at www.CODAC.org/hcpartners**

*Referred patients can expect to receive a telephone call from CODAC Health, Recovery & Wellness within 48 hours. CODAC will make three attempts to reach the patient before the referral is closed. Referring provider will be notified when patient completes first appointment or if patient does not engage in services.*