CODAC
HEALTH • RECOVERY • WELLNESS

REFERRAL FORM

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: _____

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

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.