540 Bordentown Avenue
South Amboy, New Jersey 08879
P: 732-721-1000 F: 732-952-3355
www.corehealthnj.com / info@corehealthnj.com

CLIENT REFERRAL FORM

Thank you for your referral to Core Health Services. In an effort to provide best services for the client, please provide our agency with the following information.

From: ____ Date: __________________

(Referring Agency Name)

Contact Person: ____

Phone #: _________________________ Ext. ___________ Fax #: __________________________

Address: ____

Email: ____

CLIENT INFORMATION

Client Name: _______________________________________ D.O.B.: _______________________

Aliases: ____ SS#: __________________________

Phone Number:______________________________________

DIAGNOSIS

Primary: _______________________________ Secondary: _______________________________

INSURANCE INFORMATION

Insurance Carrier: ________________________ Member ID: ______________________________

If the client is transferring from your facility, please fax us a copy of the following (if applicable):

1) Comprehensive Intake
2) Most recent toxicology results (if applicable)
3) Most recent Treatment Plan/Treatment Plan Review.
4) Signed Record Release

*One of our staff members will contact you within 24 hours of receipt of your referral. Please call our agency and inform us that a referral form is being sent so that we can adequately accommodate your request.