Eastern Virginia Advance Care, LLC
The Leader in Professional Healthcare

Substance Abuse Intensive Outpatient Program (SAIOP)

Date:_____ **Residential County:**_____

Beneficiary's Name:_____ **Date of Birth:**_____

Address:_____ **Social Security #**_____

Phone # _____**(cell)**_____**(cell provider)**_____**(Other) Race:**_____

Parent/Guardian's Name:_____ _____ **Gender:** _____**Male** _____**Female**

Medicaid: ___**Yes** ___**No** **Medicaid I.D.#:** _____ **Effective Date:**_____

Other Insurance(s): _____

Referral Source Name: _____ **Phone #** _____

Referral Source Agency: _____

What services are currently being provided to this consumer? _____

Beneficiary's School and Grade:_____

Medical Doctor:_____ **Pharmacy:**_____

Check all that apply:

- ❑ **Hospitalized within the year**
- ❑ **In detention, prison, or jail within the last year**
- ❑ **Police have been called to the home due to the client's behavior within the last 12 months**
- ❑ **Convicted of two or more serious misdemeanors within the past 12 months**
- ❑ **DSS substantiated report within the last 12 months**
- ❑ **Currently in DSS custody**

Child is involved with:

- ❑ **DSS**
- ❑ **Juvenile Justice**
- ❑ **DPI/School System**
- ❑ **LME**
- ❑ **Health Department**
- ❑ **Community Organization**

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Is the parent/legally responsible party aware of this referral:

- ❑ **Yes**
- ❑ **No**

***Please provide a copy of the custody agreement, if applicable.**

Parent/Guardian's Signature: _____

Presenting Problems:_____

_____

_____

_____

_____

_____
Referral Source Signature

For Staff Use Only

Staff receiving referral:_____ **Date:**_____

Open Record: Yes _____ **No**_____

Record # _____