Lindner Center of HOPE | UC Health

HOPE Center North
SUD Outpatient Evaluation & Treatment Services Referral Form

Please fax this form to (513) 204-3476
Or call (513) 536-0050 Office Hours M-F 7 am to 3 pm

Referring Providers,
Please Note: Completion of This Form to in its Entirety is not required for Referral of Patients to HOPE Center North. Completion of This Form to the Fullest Extent Possible at the Time of Referral Ensures the Most Rapid Response.

Date of Referral:			
Organization/Provider Making Referral			
Referring Staff Name(s)			
Referral Contact Name(s) if Other than Referring Staff			
Referral Phone Number		Referral Fax Number	
Program/Staff Email (If Applicable)			
Patient Name		Patient DOB	
Patient Phone Number		Alt. Patient Phone Number (If Applicable)	
Best Time(s) of Day to Contact?			
Alternate Contact Person for Patient and Relationship (If Applicable)		Alt. Contact Phone	
Patient Insurance/Health Plan (If Applicable)			
Health Plan ID		Health Plan Group	
Reason for Referral and Diagnosis (es) to be Evaluated and/or Treated if Known:			
Services Provided to Patient by Referring Provider & Date(s) if Applicable:			
Medications Prescribed or Administered by Referring Provider & Date(s) if Applicable:			

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Requested Services to be provided by HOPE Center North (check all that apply)

- ☐ SUD Evaluation
- ☐ Medication(s) for Non-Acute SUD Withdrawal Management (Please specify if known)
  - Methadone Buprenorphine Naltrexone
  - Acomprosate Other _____
- ☐ Medication(s) for SUD Maintenance Therapy (please specify if known)
  - Methadone Buprenorphine Vivitrol Naltrexone
  - Sublocade Acomprosate Other _____
- ☐ SUD Outpatient Therapy Services
- ☐ Psychiatry for Co-Occurring MH Disorders
- ☐ Counseling for Co-Occurring MH Disorders
- ☐ SUD Intensive Outpatient Therapy Services
- ☐ Diagnosis (es) if Known _____
- ☐ Diagnosis (es) if Known _____

Patient Consent to Share Information:
I authorize this referral source to share this form with the Lindner Center of HOPE for the purpose of discussing and scheduling my appointment.

Patient signature: _____ Date: _____

☐ Please check box if patient provided verbal consent

HOPE Center North staff will attempt to contact the patient by the next business day following referral receipt. Most patients are offered appointments within 2 business days of contact.

**HOPE Center North gives priority to patients treated by the referring provider for SUD withdrawal or maintenance needing continued medication (usually scheduled within the next business day following contact)*

For HOPE Center North Staff Use Only

Date Referral Received by HCN _____
Date(s) and Time(s) of Patient Contact Attempts _____
Assessment/Intake Appointment Scheduled on _____ Date at _____ Time

Other Outcomes:

- ☐ Left Messages for Patient to Call & Schedule & Calls Were Not Yet Returned
- ☐ Attempted to Contact Patient But Phone Number Not In Service or Incorrect
- ☐ Patient Contacted but Declined to Schedule Appointment at This Time
  Reason(s) if Known _____

Patient Not Eligible or Appropriate For Services at HCN at this Time; Patient Recommended to Contact:
_____ for services.

Please fax completed form back to referral source within 2 business days of request receipt.

Form Completed By:
_____ Staff Member
_____ Date Completed Form Faxed to Referring Provider