sagent
Behavioral Health

SUD Referral Form

Today's Date: _____

Referents Name / Facility:	**Email:**
Phone:	**Fax:**

Patient's Name:	**DOB:**
Gender:	**Last 4 # SS:**
Phone:	**Email:**
Address:	**City / Zip / County:**

Insurance Carrier:	
Insurance Holder Name:	**Holders DOB:**
Insurance ID#	**Group #:**

Notes:
_____
_____
_____

ASAM 2.1(High-Intensity Outpatient): weekly- M-TH adult three 4hour SUD groups; one SUD individual session weekly. Adolescent three 3hour SUD groups; one SUD individual session weekly.

ASAM 1.0 (Low Intensity Outpatient): weekly- M-Th adult one 4hour SUD Group; one SUD individual session weekly. Adolescent one 3hour SUD Group; one SUD individual session weekly.

ASAM 3.5 (High-Intensity Residential): daily-Monday-Sunday (30 hours a week) SUD groups, SUD individual sessions weekly.

Peer Support services are an option once admitted to any SUD program

Location: (Subject to availability)	SUD Services Request:	Other Sagent Services Request:	Include & Fax the following Documents:
Outpatient ___Alexandria ___Apple Valley ___Bemidji ___Big Lake OP ___Blaine ___Bloomington ___Cambridge ___Chaska ___Coon Rapids ___Duluth downtown ___Eden Prairie ___Edina ___Fergus Falls ___Hutchinson ___Maple Grove ___Mankato ___Minnetonka ___Moorhead ___New Brighton ___Otsego ___Rochester ___Roseville ___St. Cloud/Sartell ___Stillwater ___Woodbury **Residential** ___ Big Lake	**ASAM Level:** ___2.1 High Intensity OP ___1.0 Low Intensity OP ___3.5 High Intensity Residential **Location:** ___In-Person ___Hybrid ___Telehealth **Group Time:** ___Adult AM ___Adult afternoon ___Adult Evening ___Adolescent Evening ___Adolescent Prevention group ___Driving with Care	**Other:** ___ Counseling &Therapy ___Psychiatry & Med Management ___Adult day treatment ___Family Therapy ___Nutrition ___DBT ___ARMHS ___Case Management ___Psychological Testing ___In-home therapy for adults ___Behavioral Sleep medicine ___School-Based Therapy ___Children's' Therapeutic Services & Supports ___Mother Baby Program/Perinatal Mental Health	**Documents:** ___ROI ___Full Comp assess ___Suboxone/ MAT ___Recent TPR w Dim w/risk ratings ___DC Summ ___Diagnostic assessment ___Legal Docs (commit, PO, SOF incl level and legal docs)_____ _____ _____ _____ **Discharge Type:** ___ With Staff Approval ___Conditional WSA ___At Staff Request ___Against Staff Advice ___Medical Other_____ _____ _____

****Please fax this form and all documents****

1. Outpatient Referral: (2.1 & 1.0) SUD Fax Line: 651-604-5905 Admissions: Ph 651-529-8479

OR

2. Residential Referral: (3.5) SUD Fax Line: 763-309-2022 Admissions: Ph 763-309-2033

Thank you for the referral!