Family Service
OF THE PIEDMONT

Name:	**D.O.B.**: _/_/
F.S.P.#:	
Medicaid #:	**IPRS / LME #**:

GROUP REFERRAL FOR SUBSTANCE ABUSE / DUAL DIAGNOSIS / CONTINUING CARE GROUPS

Date: _____

Referring Therapist: _____

Referral Source: _____ Pay Source: _____

Contact Number for Client: _____ Diagnosis: _____

SAR Required? ☐ Yes ☐ No