



CONCERTED CARE GROUP BALTIMORE  
Integrated Wellness Center

### Referral Form

**Service(s) Desired:**

- Methadone Maintenance     Suboxone Maintenance     Drug Free Outpatient Program
- Substance Abuse Intensive Outpatient Program     DWI Program
- Psychiatrist     Mental Health Therapist

**Date:** \_\_\_\_\_

Applicant Name (First Last): \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Other: \_\_\_\_\_

Referral Name/Phone Number: \_\_\_\_\_

- *At this time, CCG can only accept Medicaid or self pay clients for substance abuse treatment*
  - *Mental Health services open to Medicaid, Medicare, and self pay clients*
    - *Sliding scale self pay rates available*

Medicaid/Medicare/Self Pay (please circle): ID Number: \_\_\_\_\_

Gov't Issued Photo ID: \_\_\_\_\_ Yes    \_\_\_\_\_ No    Type of ID: \_\_\_\_\_

Drug/Alcohol Use: \_\_\_\_\_

**Transfer / New (please circle)**

\_\_\_\_ Currently in MMT    \_\_\_\_ Prior MMT Tx    \_\_\_\_ Pregnant If yes, Due Date: \_\_\_\_\_

Current Treatment: Date Started \_\_\_\_\_ Name of Program: \_\_\_\_\_ Suboxone/Meth

Current Medical Problems: \_\_\_\_\_

Prescribed Medications: \_\_\_\_\_

Probation/ Parole: Yes or No    Current Legal Charges: Yes or No    Court Date: \_\_\_\_\_

**Form can be faxed to number below or emailed to**

**Kimberly McNealy, Intake Coordinator: [kmcnealy@concertedcaregroup.com](mailto:kmcnealy@concertedcaregroup.com)**

**To be completed by CCG:**

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Referral Completed by: \_\_\_\_\_ Time: \_\_\_\_\_