By my signature below, I approve my therapist to contact **POSITIVE RECOVERY SOLUTIONS** to obtain additional information and coordinate care. I have also signed a Release of Information which will be filed in my medical record.

Signature:_____ Date: _____

Medication Assisted Treatment Patient Demographic Sheet
Vivitrol Referrals for Positive Recovery Solutions
FAX to: (724) 249-2825/Phone: (412) 660-7064

County of Referral_____

Patient Name:_____ Sex: M or F

DOB:_____ SS#: _____ Valid Phone Number: _____

Address:_____
City State Zip Code

Admission Date:_____ Drug of choice: _____ Level of care: _____

Outpatient Drug & Alcohol Location_____

Counselor Name and Phone Number: _____

Insurance: Y or N **(Attach copy of insurance card)**

Person making the referral: _____Return Fax #_____

Primary Insurance Company:_____ ID/Group#_____

Secondary Insurance Company:_____ ID/Group #_____

Policy Holder: _____
Name Relationship Phone Number

Note(s):_____

_____

_____

First Contact Attempt: _____ Second Contact Attempt: _____