Patient Referral Form
CompServ health Resources Inc

Telephone: 502 561 3464 Clinic Telephone: 502 822 3802 fax: 502 792 9184

The staff and/or provider at _____ refers the below stated client to behavioral health substance use services at CompServ Health Resources

_____Substance Use Counseling _____Mental Health Counseling _____ Vocational/employment

Client Data

_____	_____	_____	_____ __
Name	DOB	Insurance ID	Insurance Carrier
_____	_____	_____	
address		telephone	

1300 South 4th Street Louisville Kentucky 40208

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CompServ Health Resources Inc

___ **Yes**, Patient/Client has completed initial appointment for intake assessment

___ **No**, Patient/Client has not completed initial appointment for intake assessment

Next Scheduled Appointment _____ (date and time).

_____ _____

Client Name

Service Recommendation _____

Please check one:

- ☐ Evening appointments preferred
- ☐ I have transportation
- ☐ I am able for morning appointments

_____ _____ _____

Comp Serv Health Staff Phone Date