Lasting Change
Treatment Referral Form

Patient/Client Information

Patient Name:_____ DOB:_____

Drug of Choice:_____ MA#:_____

County of Origin:_____ State_____ Zip:_____

HEP-C _____ HIV_____ IV Drug HX_____ # Dep. Children_____ Preg_____

Insurance Type: Medicaid_____ Medicare_____ Private_____

Last Date of Use: _____ Number of Prior Treatment Attempts _____

Has Client Been to Lasting Change in the Past?_____

Referring Treatment Program

Program Name: _____

Contact:_____

Contact Phone:_____

A Release of Confidential Information to (disclose/obtain) To/From: Lasting Change signed by the patient/client must accompany this form. We further request that all referrals forms be accompanied by any assessment completed and/or discharge summary or after care plan.

Please Fax, Email or Mail information to:
Erin Tack, LCPC
Lasting Change
519 North Locust St
Hagerstown, MD 21740
Phone: (301)-791-7826 : Fax: 301-791-1266
Email: etack@thewhouse.org