North Alabama CommunityCare

Substance Use Brief Intervention Referral Form

Cullman, Limestone, Madison, Morgan, Marshall and Jackson Counties

Please fax completed form to 256-382-2175

Recipient Name:_____ Date:_____

DOB:_____ Sex:_____ Recipient/Guardian Phone: _____

Medicaid #:_____ Primary Language: _____

Address:_____

Emergency Contact:_____ Phone:_____

Referring Physician/Facility: _____

Physician Office Contact Name and Number: _____

Reason for Referral _____

_____

_____

_____

❑ **Referral to NACC for Substance Abuse Disorder Brief Intervention Coordination**

Patient in need of brief intervention care coordination due to Substance Abuse Disorder