North Alabama
CommunityCare

Substance Use Brief Intervention Referral Form

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

Please fax the completed form to 256-382-2715

Recipient Name: _____ Date: _____

DOB: _____ Sex: _____ Primary Language: _____

Medicaid #: _____

Recipient/Guardian Phone: _____ Alternate Phone: _____

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 Use Disorder