COVE
BEHAVIORAL HEALTH

EVALUATION REFERRAL

PATIENT INFORMATION
Name:
D.O.B.:
Phone: **email:**
Alternate Contact:
MEDICAL INFORMATION
Insurance:
Admission date: **Discharge date:**
Behavioral Health Dx:
Medical Dx:
Recommendation:
EVALUATION/S NEEDED SUD ☐ MH☐ MAT ☐
DETOX ☐ Followed by SUD/MH/MAT Evaluation upon discharge ☐
Medications prescribed:
Was patient dosed for Opioid Use Disorder? YES☐ NO☐
Suboxone Dose: 8/2x1 8/2x2 8/2x3 8/2x4 **Methadone Dose:** **NARCAN® Kit Given: YES ☐ NO☐**
Time Dose administered: AM ☐ PM ☐
Discharge plan attached: YES ☐ NO☐
Patient Consent attached: YES ☐ NO☐
UDS Panel and/or LABS completed: YES ☐ NO☐ Results: YES ☐ NO☐
Barriers to TX follow up: Transportation ☐ Motivation ☐ Other ☐

Email to admissions@covebh.org or Call Admission Manager at 813-384-4134