gateway FOUNDATION

Addiction Medicine.
Saving Lives.

Referral Form
Patient Treatment

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Is it okay to leave a message at this number? ☐ Yes ☐ No

Parent or legal guardian name, if under 18 _____ Payer Source ☐ Insurance ☐ Private Pay ☐ Unfunded ☐ Medicaid ☐ Other

REFERRAL SOURCE INFORMATION

Referral Name _____ Organization _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Fax _____

PREFERRED TREATMENT CENTER

Illinois

- ☐ Aurora
- ☐ Carbondale
- ☐ Caseyville
- ☐ Chicago Independence
- ☐ Chicago Kedzie
- ☐ Chicago River North
- ☐ Gurnee
- ☐ Jacksonville
- ☐ Joliet
- ☐ Lake Villa
- ☐ Pekin
- ☐ Springfield
- ☐ Springfield Outpatient
- ☐ Swansea

Delaware

- ☐ Smyrna

California

- ☐ Beacon House
- ☐ Beacon House Outpatient

CONSENT TO CONTACT

Referral Source Signature _____ Date _____

Patient Signature _____ Date _____

FAX COMPLETED FORM TO: 888.975.0939