With this signature, I agree to release my information to the secondary contact, confirm future appointments, and to release my information to the counselor listed below.

*Signature:_____ *Date:_____

Medication Assisted Treatment Patient Demographic Sheet
Vivitrol Referrals for Positive Recovery Solutions
Phone: (502) 749-7008
Email: PRSKentucky@gmail.com

*** County of Referral** _____

*** Patient Name:**_____ *** Sex: M or F**

*** DOB:**_____ *** SS#:** _____ *** Valid Phone Number:** _____

*** Address:**_____
City State Zip Code

*** Drug of choice:** _____

*** Outpatient Drug & Alcohol Location:** _____

*** Name of Vivitrol Coordinator / Lead Therapist / Lead Counselor at Location:**_____

*** Phone Number / Email For Vivitrol Lead at Location:** _____

*** Patients Counselor Name:** _____ *** Phone Number:**_____

*** Person making the referral:** _____ *** Email/Phone #**_____

*** Insurance: Y or N (Attach copy of insurance card)**

*** Primary Insurance Company:**_____ *** ID/Group#** _____

Secondary Insurance Company:_____ **ID/Group #**_____

*** Patients Secondary Contact Name:**_____

*** Relationship to Patient:** _____ *** Phone Number:**_____

Note(s):_____

_____