Date of Form Submission:

TEAM Wellness at Work

Notification Review for New In/Outpatient Chemical Dependency Services

This request is to be used only for **NEW IN/OUTPATIENT CHEMICAL DEPENDENCY SERVICES** for a client. To report a client's CD treatment progress, please use the "**Chemical Dependency Progress Report**" form, which can be found at www.team-mn.com.

Please print clearly. Incomplete or illegible forms can not be processed.

Client Information

Client's Name

Client's Date of Birth

Client's Address

Client's Phone #

Group #

ID #

Policy Holder's Name

Diagnosis and Date of Last Use

Provider Information

Services Requested (Inpatient, IOP, Relapse, MAT [Medication Assisted Therapy], etc.)

Program Length / # of Sessions

Clinician's Name and Credentials

Clinic Name and Address

Name of Requestor

Requestor's Phone #

Requestor's Email Address & Fax #

Requested Start Date of Service

For (MAT) medication assisted therapy, please list medication and dosage:

Additional Comments:

IMPORTANT: Please attach copy of completed CD Evaluation as referrals cannot be processed without a current evaluation.

Submit completed forms via email or fax to TEAM

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