Referral

Person Making Referral

First Name: *

Middle Name:

Last Name: *

Title:

Company/School:

Address:

City: *

State: *

Zip: *

County:

Email Address: *

Supervisor Name: (if different from above)

Day Telephone: (format xxx-xxx-xxxx) *

Relationship of Person Making Referral to Practitioner (Choose only one)

Make a Selection: *

- Employer
- Self
- Coworker
- Family Member
- College/University
- Attorney/Law Enforcement

Other

Reason for Referral/Report (Check all that apply)

- [ ] UDS in Workplace
- [ ] Alcohol
- [ ] Behavior (Anger Management, Disruptive), Mental Health
- [ ] Criminal Arrest/Conviction
- [ ] Drug Diversion
- [ ] Eating Disorder
- [ ] Forgery
- [ ] Illegal Drug Use
- [ ] Impairment
- [ ] Other
- [ ] Quality of Care (Charting-Patient Abandonment-Neglect)
- [ ] Sexual Abuse, Harassment or Contact
- [ ] Substance Abuse-Dependency
- [ ] Unethical Conduct

Specify Other if Category Checked Above:

Specify Unethical if Category Checked Above:

Work Setting (Check only one)

- ( ) Hospital
- ( ) Agency
- ( ) Nursing Home-Long Term Care
- ( ) Office
- ( ) College-University-School
- ( ) Community-Public-Government Agency
- (•) Ambulance Service
- ( ) Other

Practitioner Information (Subject of Referral)

Practitioner First Name: *

Practitioner Middle Name:

Practitioner Last Name:

Title of Practitioner:

Practitioner Company/School:

Social Security Number:

Date of Birth: (format mm/dd/yy) *

Practitioner Address: *

Practitioner City: *

Practitioner State: *

Practitioner Zip Code: *

Practitioner County:

Practitioner Home Telephone:
(format xxx-xxx-xxxx) *

Practitioner Mobile Phone:

Profession: Rph, DDS,
etc.

Practitioner WV License
Number(s): *

Other states licensed and
license numbers.

Details of Complaint: Please provide pertinent information, such as the sequence of events surrounding your concern in Chronological order, and please also provide the names of others who are aware of or who witnessed the events.* You can also attach any allegation (complaint information to this form or fax to our HIPPA encrypted fax at (606)832-0077.

Date(s) Above Incident(s)
Occurred: *

Was Pharmacy Involved? * ○ Yes
○ No

If yes, Name and Address of
Pharmacy:

Please Read the Following and Click the Box Below:

I certify and affirm that the
information provided herein is
complete and accurate to the
best of my knowledge: * ☐ Affirm

Date Submitted: (mm/dd/yy) *