Universal Referral Form

Consumer/Service Recipient Name: ____

Telephone: ___________________________ Secondary form of contact: _______________________

Date of Birth: / / Gender (optional): ☐ F ☐ M ☐ Other ☐ Would rather not disclose

Address: ____

County of Residence: ______________________________ Date: __________________________

Email:_______________________________________

Referral Source/Name: ___________________________ Telephone: ___________________________

Has the recipient survived an opioid overdose within the last 6 months? ☐Y ☐N

Arrested or incarcerated for a drug related offense within the last 6 months? ☐Y ☐N

Service Requested (Choose all that apply):

☐Peer Support

☐Individual Skill Development and Enhancement

☐Individual and/or Family Psychoeducation

☐Wellness Management and Recovery

☐Employment Related Skills Training

☐Medication Assisted Treatment (Vivitrol)

☐ Family Recovery Support and Education

☐ Community Service

Please note any requests for specific provider(s):

____

____

Case Number: ____________________________________

Diagnosis: ____

Has there been a primary or co-occurring opioid use disorder in recipient's history? ☐Yes ☐ No

Service Facilitator/Social Worker Name: ____

The following materials have been included with this referral:

☐CCS Service Authorization ☐CCS ISP ☐CCS Assessment ☐Grant Intake Form

*Please send all referral to lrccinformation@gmail.com Phone: 920-374-4433